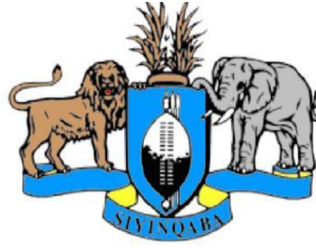

Eswatini HIV Prevention 2025 Road Map

Ending AIDS as a Public Health Threat by 2025

NERCHA

15th October 2023

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Abbreviations

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immuno-Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral medicine
CBO	Community-Based Organisation
CHIMSHACC	Chiefdom Multisectoral HIV and AIDS Coordinating Committee
CLM	Community Led Monitoring
COP	Community of Practice
COVID	Corona Virus Disease
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisations
DHIS 2	District Health Information System - 2
DR-TB	Drug Resistant Tuberculosis
DREAMS	Determined, Resilient, AIDS free, Mentored and Safe
DS-TB	Drug Sensitive Tuberculosis
DSD	Differentiated Service Delivery (models)
eMTCT	Elimination of Mother to Child Transmission
ESA	East and Southern Africa
FBO	Faith-Based Organisation
FODSWA	Federation of Disability in Swaziland
FP	Family Planning
GBV	Gender-Based Violence
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
IP	Implementing Partner
IPR	Incidence To Prevalence ration
ITM	Incidence To Mortality ration
KII	Key Informant Interview
KVP	Key and Vulnerable Population
LGBTI	Lesbians, Gay, Bisexual, Transgender and Intersex
LSE	Life Skills Education
M&E	Monitoring and Evaluation
MCP	Multiple and Concurrent Partnerships
MOET	Ministry of Education and Training
MOH	Ministry of Health
MSM	Men who have Sex with Men
MTCT	Mother To Child Transmission
NERCHA	National Emergency Response Council for HIV and AIDS
NSF	National Strategic Framework
OI	Opportunistic infections
OPM	Office of the Prime Minister
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PHDP	Positive Health Dignity and Prevention
PISHACC	Public Sector HIV and AIDS Coordinating Committee
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Eexposure Pprophylaxis

PSS	Psychosocial support
PWD	People with Disability
PWID	People Who Inject Drugs
REMSHACC	Regional Multisectoral HIV/AIDS Coordinating Committee
RR/MDR TB	Rifampin Resistant / Multidrug resistant Tuberculosis
SASA	Students Achievement and School Accountability
SBCC	Social and Behaviour Change Communication
SDG	Sustainable Development Goals
SHIMS	Swaziland HIV Incidence Measurement Survey
SMC	Safe Male Circumcision
SODV	Sexual Offences and Domestic Violence
SRH	Sexual Reproductive Health
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TFR	Total Fertility Rate
TG	Transgender
TIMSHAAC	Tinkhundla Multisectoral HIV and AIDS Coordinating Committee
TWG	Technical Working Group
U=U	Undetectable = untransmissible
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV and AIDS

Foreword

Eswatini has made significant progress to address HIV and AIDS challenges. Despite the efforts the epidemic remains the greatest sustainable human development challenge. AIDS have affected the quality of life and compromised life expectancy. Many people especially key and vulnerable populations remain at a higher risk of HIV infection. Almost one in every five persons in the communities have experienced the effects of the epidemic. Today the epidemic continues to spread along the fault lines of social and economic development processes.

Eswatini is committed to end AIDS as a public health threat by 2025. In the past Eswatini have worked very hard to stop the spread of HIV and move fast towards epidemic control. HIV incidence dropped by 44%, and Eswatini was among the first countries in the world to achieve the 90-90-90 targets by 2020. Today we have surpassed the second (97%) and third (96%) of the 95-95-95 targets and have come very close to achieve the first 95 target where we stand at 94%. To achieve the goal of ending AIDS as a public threat, we have to work together, with absolute determination, and target populations that are most vulnerable or at higher risk of HIV infections.

The strategies we propose in this Road Map will help us to halt the spread of HIV and start reversing its health, social and economic impacts. To do so we must prioritise HIV prevention, identify the drivers of the epidemic, and take appropriate actions. We must strengthen the capacity for HIV prevention and sustain adequate investments to ensure efficient and effective HIV prevention services delivery. Equally we must strengthen the social, policy and legal enabling HIV prevention environment to support access and utilisation of available services

While we mobilise and galvanise meaningful community engagement and participation, leaders at all levels must provide the necessary and sustained political leadership and commitment for HIV prevention. Without such commitment and leadership, we as leaders will have failed the people of Eswatini, who have given us the privilege to lead and secure a healthy future.

The HIV Prevention Road Map 2025, redefines our strategies and prioritises high impact HIV prevention interventions. We now need to intensify and accelerate their implementation coupled with sustainable financing. The Road Map provides a comprehensive plan, that if implemented well will yield the desired results. I therefore urge all the stakeholders to take the right actions, implement them with the right intensity and coverage, target the right population groups in their respective geographical locations. We must come together to improve coordination and accountability for HIV prevention.

The Government will do its part of upholding the commitment to human rights and gender equality, and elimination of all forms of stigma and discrimination. It will endeavour to end all forms of inequalities that prevent HIV prevention. We shall mobilise the required domestic and external resource to support HIV prevention initiatives. We will keep watch and respond swiftly to other epidemics such as COVID-19, so that they do not disrupt our prevention activities.

Finally our communities remain the corner stones of HIV prevention. The Road Map is designed to stimulate and support community-based, and community led HIV prevention interventions, including Community Led Monitoring (CLM) and reporting on progress and performance towards the agreed targets. It is our collective duty to secure our future as a nation by addressing the epidemic meaningfully today.

Mr. Kanya Mabuza
National Executive Director / NERCHA

Acknowledgements

The development of the HIV Prevention 2025 Road Map was commissioned by NERCHA in collaboration with other stakeholders including Ministry of Health (MOH) and UNAIDS. The process was facilitated by the Core Team and the National Multisectoral HIV Prevention Technical Working Group (TWG). While some work was done in country, some work was done remotely on line especially with regard to stakeholder consultations.

A participatory process was adopted to ensure meaningful and active participation and engagement by all stakeholders. Stakeholders participated in different ways including - Focus Group Discussions (FGD), Key Informant interviews (KII) and in different consultative worships. They were drawn from government agencies, civil society organisations (CSO), private sector, local authorities, and development partners. Equally, sector coordinators played a key role in convening and organising sector-based consultations. Regional consultations were facilitated by NERCHA Regional Coordinators in collaboration with the national consultant. The consultations generated strategic information that has informed the development of the Road Map and in particular in improving the overall quality, coverage and scope of Road Map. Without stakeholder's meaningful engagement and participation, the development of the Road Map would have been greatly compromised. NERCHA is sincerely grateful for their contributions, support and commitment.

The Government of the Kingdom of Eswatini is grateful for the financial support by UNAIDS to support the process including the recruiting of both national and international consultants, in addition to financing the Steering Committee, Core Team, Sector and Regional consultations.

NERCHA is particularly grateful to the members of the high-level Steering Committee, chaired by the Principal Secretary in the Office of the Prime Minister (OPM), who provided policy oversight, technical and political leadership. Similarly NERCHA is grateful to the Core Team, who provided technical oversight and quality assurance. Their involvement and participation were critical in ensuring that the Road Map focused on strategic high impact interventions and prioritised key and vulnerable populations (KVP) at higher risk of HIV infection. NERCHA management wishes to extend its appreciation to all its staff who supported the process in various ways ranging from administration, logistics, and outreach. It would have been almost impossible to mobilise, engage and conduct stakeholder consultations without their support.

Finally, NERCHA wishes to thank the National Executive Director Mr Khanya Mabuza,the Head of Programmes, Mr Mphikeleli Dlamini and the National HIV Prevention Manager, Mr Mazwi Mavuso for their leadership, commitment and support for the entire process, ensuring that the process went as planned. Thank you. Similarly we wish to thank the International Consultant Dr Simon Muchiru, and the National Consultants Ms Pholile Dlamini, and Ms Zandile Nkambule who were recruited by Oakwood Consultants to provide in-country support. They were key in conducting the stakeholder consultations, and in managing the Road Map development process. Without their dedication, patience and commitment, the development of the Road Map would have remained a challenge.

Eswatini is grateful for the collective and concerted effort to develop the HIV Prevention 2025 Road Map. Thank you

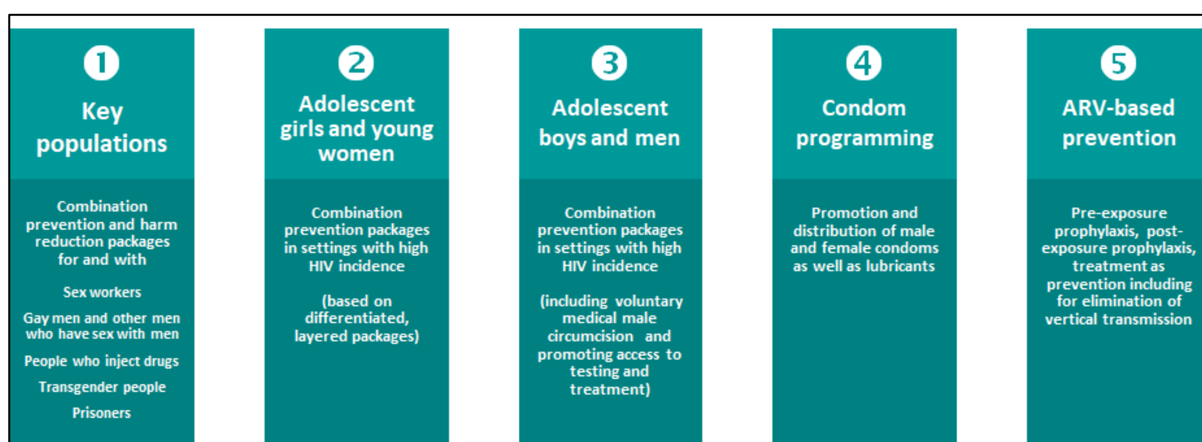
Mr Mphekileli Dlamini -
Head of Programmes / NERCHA

Executive Summary

HIV and AIDS remains a significant challenge to socio-economic development of Eswatini. However Eswatini has made great progress in addressing the HIV epidemic. It was among the first countries in the world to achieve the 90-90-90 targets by 2020. Today Eswatini has surpassed the second (97%) and third (96%) of the 95-95-95 targets and have come very close to achieve the first 95 target, standing at 94%. Eswatini has committed to end AIDS as public health threat by 2025, and pave the way to end AIDS by 2030.

The Eswatini HIV Prevention 2025 Road Map is intended to guide and inform the HIV prevention response in prioritising, intensifying, accelerating and scaling up high impact HIV prevention targeting populations most at risk. The Road Map is aligned with the Global HIV Prevention 2025 Road Map, the National Multisectoral Strategic Framework on HIV and AIDS 2023 - 2027, and the National Health Sector Strategic plan 2019-2023[1]. The five pillars identified in the figure 1 below constitute the core of the HIV Prevention Road Map prioritised response *(see section 4 for details on each pillar).* They also serve to align the Eswatini HIV Prevention Road Map with the Global Prevention 2025 Road Map.

Figure 1: HIV Prevention 2025 Road Map – Pillars



The Road Map has established minimum packages for HIV prevention for each of the above populations, that are intended to be delivered using the "combination prevention" approach. The Road map goes further to infuse "precision prevention" in order to ensure strategic targeting, of interventions to address specific needs of individuals or sub populations. It is on this understanding that the Road Map advocates for "differentiated Service Delivery (DSD) models" that will ensure services resonate with individual needs and make precision prevention more effective.

In the case of key populations i.e. men who have sex with men (MSM), female sex workers (FSW), Transgender (TG), and people who inject drugs (PWID) and prisoners, the priority will be strengthening an enabling social, policy and legal environment, which is necessary for planning and delivering services to them. Currently the practices of most key populations Eswatini are criminalised, and individuals risk being stigmatised and discriminated or harassed by law enforcement officers. Access to services will be improved, including devolving service delivery to community level, ensuring services are adequate and

[1] Note: The new successor strategies are being finalised covering the period 2023 – 2027 and will be available in September 2023.

user friendly. Strategies have been suggested at operational level that will strengthen key population led / managed organisations.

The primary focus of the Road Map for adolescent girls and young women (AGYW) and adolescent boys and young men (ABYM) is to ensure effective and efficient HIV prevention services are readily available and accessible to them especially in rural communities, and institutions of learning. AGYW will be given priority given their higher risks and vulnerabilities.

The Road map interventions go beyond direct HIV prevention, to addressing factors that make AGYW more vulnerable. Such strategies include ensuring that life skills are provided for both in and out of school young people especially 10-19 year olds, keeping girls in schools, addressing risk factors such as intergenerational and transactional sex, and multiple and concurrent partners (MCP). Demand creation for service among young people will be intensified using different approaches.

Outreach services to boys and men will be increased and intensified, offering critical services such as HIV testing, linking them to prevention and or treatment services as appropriate, and encouraging them to participate in more effective and efficient HIV prevention services such as PrEP and consistent use of condoms.

The Road map calls for a review of current service delivery systems to ensure availability, equitable distribution across the country, efficient procurement systems to avoid stockouts, and improved capacity and accountability of service providers. A comprehensive Coordinating and Accountability Framework has been developed to improve efficiency, effectiveness and the degree of accountability.

Scaling up of ARV-based HIV prevention including ART, PrEP, PEP, and ART for PMTCT is a prioritised strategy. It is evident that ARV has great potential to contribute to HIV prevention based on the U=U theory. Despite this understanding, these services are not easily accessible to all people including some key populations, AGYW or even ABYM. Expanding the outreach and partnerships will ensure availability and easy access at community level.

In addition to the five pillars the Road Map will also address and mitigate the impacts of epidemics such as COVID-19 on service delivery, adherence and retention. COVID-19 exposed the fragilities and resilience of health and community systems and disrupted access and delivery services through lockdowns, travel restrictions and isolation. The pandemic also disrupted and brought to a halt community outreach services and the supply chain for medicines and other health commodities. A key consideration of the Road Map is ensuring that effective “preparedness” strategies are put in place to address pandemics when they occur, or in case of COVID-19 re-occurring.

The Road Map aims at ambitious HIV prevention outcomes as indicated in the table 1- below

Table. 1: HIV Prevention 2025 targets

	Indicator description	**Target (2025)**
1.	HIV incidence rate among people aged15-49 reduced	<0.4%
2.	HIV incidence rate among people aged 15-25 reduced	<0.4%

3.	% of infected infants aged 18-24 months who are born to HIV positive mothers reduced	<0.1%
3.	New HIV infections reduced by	75%
4.	Number of new infections among AGYW (15-24 Years) reduced	50%
5.	Number of new infections among key populations – FSW, MSM & TG by	50%
6.	95-95-95% HIV testing, treatment and Viral suppression achieved at sub population level (disaggregated by sub population, gender and age)	95-95-95
7.	% of PLHIV and key populations experience stigma and discrimination	<10%
8.	% of PLHIV and key population experience gender-based inequalities and GBV	10%
9.	HIV Prevention is sustainably funded from both domestic and external funding	100%
10	All policy, legal and human rights barriers to HIV prevention addressed and removed	100%
11	To ensure that 95% of all people in need, have access to and utilise comprehensive combination HIV Prevention services.	95%
12	An efficiently coordinated HIV prevention response and stakeholders are accountable	NCPI

The Road Map is cognizant of the fact that Eswatini has achieved the second and the third of the 95-95-95 targets at national level. However, this is not the case at sub-population levels especially among key and vulnerable populations including AGYW.

The epidemiological data used in the road is derived from SHIMS (2021) and Estimates and Projection (2022), in addition to other programme review reports. The data helps to identify strategic prevention gaps and support the articulation of precision high impact interventions. Section 2, of the Road Map has also highlighted the strategic drivers of the epidemic in Eswatini

With an ambitious outlook into 2025, ESwatini in Section three (3) has reviewed and redefined its strategic HIV prevention directions, objectives and guiding principles. Section three further discusses the paradigm shifts in planning and service delivery focusing on evidence-based, and human rights approaches complemented by “differentiated service delivery (DSD) model. The service delivery approach shifts from one fit all approach to precision prevention, from national to geographical locations with high disease burden and prevention needs, from the general approach in service delivery to differentiated service delivery (DSD) models.

It is also evident that addressing and delivering core services without addressing the enabling factors will not serve the purpose. Hence section four (4) has identified the critical social and programmatic enablers that include combination prevention, advocacy and communication, social and behaviour change communication (SBCC), social and community mobilisation. Section four further articulates strategies to remove human rights, social, policy and legal barriers to HIV prevention, identifies and prioritises strategic high impact HIV prevention interventions. The Road Map acknowledge the impact of ART on HIV prevention and hence has prioritised ARV based HIV prevention interventions including ART, PrEP, PEP and PMTCT.

Combination prevention remains the bedrock of the Road Map implementation complemented by DSD targeting specific sub-populations and addressing their needs. The implementation strategies have

integrated activities necessary to address societal enablers and address underlying social and economic inequalities, social, policy, legal and human rights barriers to HIV prevention.

The Road Map will bring HIV prevention to scale, significantly improve availability and quality of services, the efficiency and effectiveness of service delivery, and further improve HIV prevention coordination and stakeholders accountability for HIV prevention. The Road Map advocates for strengthening the social, policy and legal enabling environment necessary to support and improve access, utilisation and retention of clients on HIV prevention programmes. In particular the Road Map presents specific interventions to address social, human rights, policy and legal barriers to HIV Prevention service. It is designed to put people first, at the centre of planning and service delivery. By doing so the Road Map will ensure that nobody is left behind, and that essential services are available, accessible and are being utilised.

The Road map will inspire and shape HIV Prevention policies, resource allocation, service delivery practices and advance knowledge of HIV and AIDS. Specific interventions are designed to improve and strengthen coordination, accountability, tracking and reporting of progress and performance

Targeting KVP will be premised on a number of factors such as age, gender, the Key population, geographical location (rural, urban, high disease burden), awareness and knowledge of HIV and or HIV services among other factors. This will be in addition to using evidence-based epidemiological data that help to understand disease burden in specific sub populations and geographical locations.

The HIV prevention packages are designed to address biomedical, behavioural and structural (social and economic inequalities) needs and barriers to HIV prevention by different target groups. Interventions will contribute to a reduction of exposure to HIV, probability of transmission and influence change in societal norms, values and practices that impact negatively on HIV prevention. In addressing societal norms, values and practices, interventions will include those that increase awareness and improve comprehensive knowledge on HIV, address sexuality and reproductive health and rights, support reduction of risky sexual behaviours and empower AGYW, boys and men.

Although the road map has not prioritised women in general and people living with disability, they are considered vulnerable to HIV infections. In view of this consideration the Road Map suggests that implementing partners not only maintain but also accelerate the implementation of current prevention interventions that target women and other vulnerable populations such as people with disability (PWD). Women will also be targeted as sexual partners in different targeted male sub population groups such as migrant and mobile workers, and in some instances as sexual partners of some MSM and male sex workers.

Exposure to HIV infection will be addressed by implementing interventions that deal with early sexual debut, multiple and concurrent partnerships (MCPs), inter-generational sex, promote and support correct and consistent use of condoms, safe male circumcision (SMC), PrEP and PEP. Improving access and treatment of sexually transmitted infections (STIs) will reduce exposure to HIV infection especially among AGYW, boys and men, and key populations. The prioritised interventions will further address social and economic inequalities that drive or influence HIV infections including income inequality, mobility and migration, sex work, gender inequalities, sexual and gender-based violence (GBV).

The Road Map highlights critical issues and strategies to strengthen HIV Prevention Coordination and Accountability. However, to complement the Road Map Eswatini has developed the accompanying Framework entitled “The Eswatini HIV Prevention Coordination and Accountability Framework”. The

Framework in particular calls for implementing partners to ensure accountability for financial resources, the services they deliver and “promises” they make to beneficiary communities.

The implementation of the Road Map demands sustained and efficient use of evidence-based strategic information and data to inform decisions, actions, resource allocation, and service delivery. This is in addition to strengthening the capacity of stakeholders, especially for communities.

Section 1: Background Information

1.1 The Eswatini HIV Prevention 2025 Road Map -Introduction

Eswatini has developed the HIV Prevention 2025 Road Map to strategically refocus its multisectoral and decentralised HIV prevention response, bringing prioritised interventions to scale and significantly improving availability, accessibility, acceptability, utilisation and quality of comprehensive HIV prevention services. The Road Map will inspire and shape HIV prevention policies and legislation, influence service delivery practices, improve the efficiency and effectiveness of coordination and accountability mechanisms and strengthening sector-based HIV prevention programmes.

The Road Map suggests strategies to address social, human rights, policy and legal barriers to HIV prevention services. The Road Map puts people at the centre of planning and service delivery and by doing so, it will ensure that nobody is left behind. It will inspire and shape HIV prevention policies, resource allocation, service delivery practices and advance HIV and AIDS knowledge.

The implementation of the Road Map will be premised on proven overarching and cross cutting approaches including combination prevention, advocacy and communication, SBCC, social and community mobilisation. While these approaches are distinct, they are complementary, and when used together they improve programme synergies especially in service delivery. Service delivery will be premised on programme specific targeted and differentiated HIV prevention packages designed to resonate with the need and desires of the target key and vulnerable populations.

Targeting will be premised on different factors including but not limited to age, gender, the type of Key population, geographical location (rural, urban, high disease burden), awareness and knowledge of HIV and or HIV services. The packages are designed to address biomedical, behavioural and structural (social and economic inequalities) needs and barriers to HIV prevention by different target groups. Specific interventions will contribute to the reduction of exposure to HIV, probability of transmission and influence change in societal norms, values and practices that impact on HIV prevention. The interventions will contribute to increasing and improving awareness and comprehensive knowledge of HIV, address sexuality and reproductive health, support reduction of risky sexual behaviours and empower AGYW, boys and men. Special attention will be paid to out of school adolescent girls and boys where currently there are no formal strategies to provide life skills and advance best practices in sexual and reproductive health (SRH) for both out of school girls and boys.

Strategies to address exposure to HIV infection will include interventions such as delaying early sexual debut, reducing MCPs, inter-generational sex, promoting and supporting correct and consistent use of condoms, SMC, use of PrEP and PEP among others. Improving access and treatment of STIs will also reduce exposure to HIV infection especially among AGYW, boys and men, and key populations. The prioritised interventions will address social and economic inequalities that drive or influence HIV infections including income inequality, mobility and migration, sex work, gender inequalities, sexual and GBV.

Issues and strategies for HIV prevention coordination and accountability are addressed in detail in the accompanying framework entitled “The Eswatini HIV Prevention Coordination and Accountability Framework”. The framework calls for improved and strengthened coordination, has articulated roles and responsibilities for different implementing partners. The Framework further calls for improved

accountability for financial resources, services and promises made to intended beneficiaries, particularly in the context of sustainability. The interventions will strengthen community system's resilience and flexibility.

The Road Map will also promote and support sector-based HIV prevention interventions. Sectors will be encouraged to mainstream HIV prevention activities in their on-going workplace wellness programmes and also target staff working in the field in development projects, including communities that live within the project vicinity. During the implementation of the Road Map sector capacity to plan and delivery sector-based HIV prevention interventions will be assessed and strengthened.

1.2 Country Profile

Eswatini covers an area of 17364 square kilometres. The country is divided into four administrative regions of Hhohho, Manzini, Shiselweni and Lubombo. The population is estimated at 1,093,238 (Women: 51.4%, men: 48.6%). Seventy eight percent (78%) of the population live in rural areas. Manzini has the highest (33%) population followed by Hhohho (29%). 60% of the population is between 15 and 64 years, while 36% are children between 0-14 years. In 2022, population growth rate was estimated at 0.7%, while the total fertility rate (TFR) is estimated at 2.8 birth per 1000 women. More than 50% of the population are young people with a median age of 21.4 years. Agriculture and mining are the backbone of the economy. 58.9% of the population live under poverty datum line[2].

1.3 The Goal and Strategic Objectives of the HIV Prevention 2025 Road Map

The Road Map is an ambitious multisectoral and decentralised strategy designed to effectively and efficiently drive HIV prevention programmes with the aim of achieving an epidemic control. The primary focus is preventing new HIV infections from occurring. To achieve this goal the Road Map implementation will be guided and informed by the following five strategic objectives –

Table 2: Road Map Strategic Objectives

Strategic Objective 1:	To intensify and accelerate the implementation of prioritised high impact HIV prevention interventions targeting KVP at higher risk of HIV infections,
Strategic Objective 2:	To ensure the adoption and implementation of the combination and precision HIV prevention approaches based on age, gender and other social characteristics of targeted beneficiary.
Strategic Objective 3:	To strengthen the multisectoral coordination and accountability mechanisms for HIV prevention.
Strategic Objective 4:	To intensify demand creation for HIV prevention through accelerated social and behaviour communication, and social and community mobilisation.
Strategic Objective 5:	To galvanise political support, commitment and leadership that will ensure sustainable financing, necessary to bring HIV prevention to scale, at all levels of society.

[2] Swaziland Population and Housing Census (2017),

1.4 Guiding Principles

The implementation of the Road Map will be guided by the following Principles.

a) **People-Centred Interventions**: All the proposed interventions will consider the best interest of the prioritised key populations at all points from planning, implementation, to service delivery. Implementing Partners (IP) will ensure adequate mobilisation, and meaningful engagement and participation by KVP. Meaningful participation may require KVP being capacitated with appropriate skills and other resources i.e. Funding, and strategic information.

b) **Accountability for HIV Prevention**: The Road Map calls for accountability by service providers and beneficiaries, policy makers and development partners that is anchored on the principles of shared and common interests, resources, risks and benefits.

c) **Protection, Respect and Fulfilment of Human Rights**: The planning and delivery of all services will be anchored on promoting, protecting and fulfilling KVP human rights. Special attention will be paid to addressing stigma and discrimination, and removing policy and legal barriers to access to services.

d) **Social and Economic Inequalities:** The Road Map advocates for strategies that address both social and economic inequalities including gender. It calls for gender sensitive and responsive interventions.

e) **Multi-sectoral and Decentralised approach**: To expand the scope and coverage of the HIV prevention, the Road Map calls for strengthening and harmonising the multisectoral and decentralised approaches with emphasis on reaching out beyond the health sector.

f) **Political leadership and commitment**: The Road Map call for strong political leadership and commitment, good governance and accountability for HIV prevention at all levels and sectors.

1.5 HIV Prevention Road Map - Justification

Eswatini has made significant progress in addressing HIV and AIDS. Available epidemiological data (SHIMS 3, 2022 Estimates and projections) show that Eswatini has achieved the 90-90-90 targets and surpassed the second and third 95-95-95 targets. All indications show that the country was on the road to achieve epidemic control and even eliminate mother to child transmission of HIV. New HIV infections have declined, more people living with HIV are on treatment and have achieved viral suppression. Access to HIV prevention services by KVP have improved despite the existing human rights, policy, social and legal barriers. However Eswatini recognise and is committed to ensuring that the kingdom achieve all the 95-95-95 targets at sub population level.

Analysis of SHIMS 3 and Estimates and Projections (2022) Data show a decline in HIV infections and AIDS related deaths between 2018 and 2022. However, the same data suggest that new infections and AIDS related deaths will increase between 2023 and 2024 indicating a reversal of the decline trajectory. For Eswatini to get back on HIV prevention track, the country needs to review and assess current and emerging challenges and bottlenecks preventing HIV prevention. Using the same approaches and expecting new and better results is impossible. Two things must happen, and happen quickly. First, identify and assess the social, policy, legal and human rights barriers that prevent HIV prevention, and isolate and identify the root causes of the bottlenecks. Eswatini has to come out of the comfort zone,

embrace and use strategic evidence-informed choices and decisions on how to address HIV prevention bottlenecks. Unless we know the root cause, we cannot meaningfully respond to a problem.

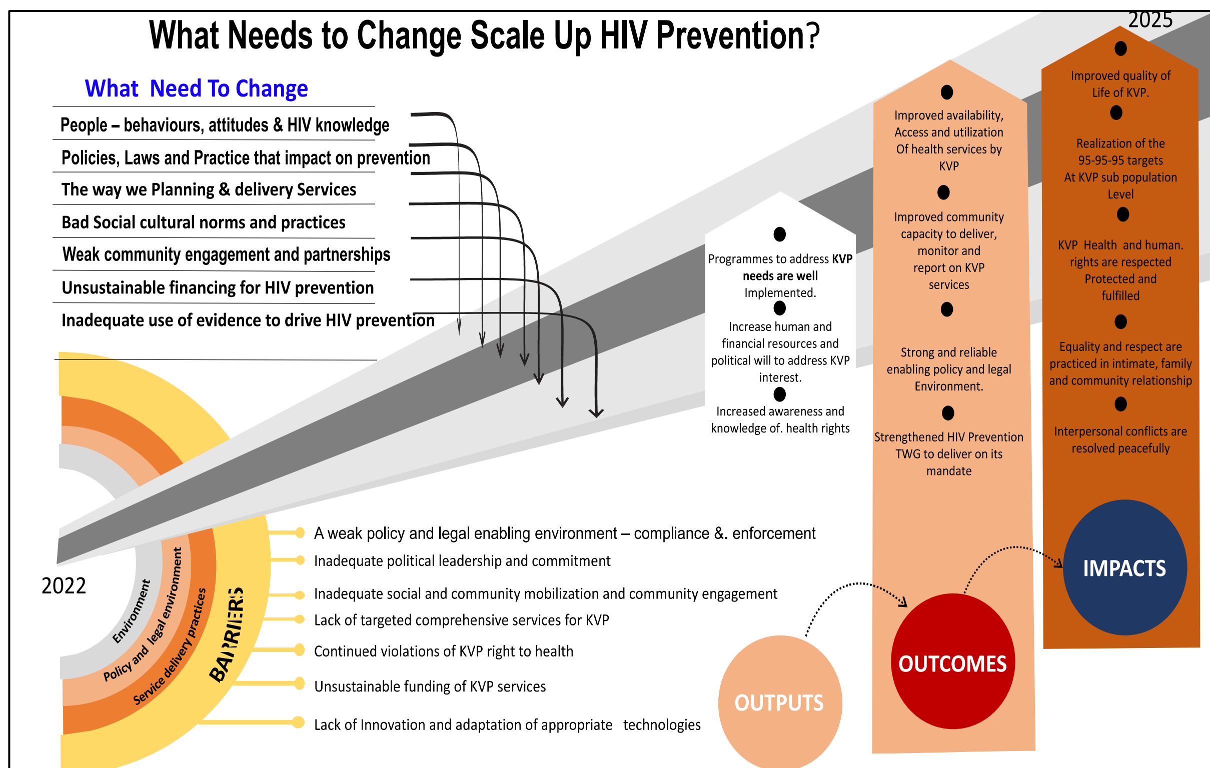
Secondly, Eswatini has to identify what is working, emerging best practices, new innovations, and technologies, to support the scaling up and accelerating the implementation of effective HIV prevention strategies. This demands strong political leadership and commitment, sustainable and adequate financing for HIV prevention, and effective mobilisation, engagement and participation by communities. A strong policy, legal and social enabling environment becomes a pre-requisite.

The theory of change advanced in the Road Map, explores what must change, how and when in order to ensure positive impact on halting and even reversing the trajectory of new HIV infections, moving on to achieve an epidemic control and eventually ending AIDS by 2030.

There is an urgent need to change the "mindset" from doing HIV prevention as usual to focusing on people and measurable results, using best practices and available evidence, avoiding temptations to focus on what we are familiar with or like most. Implementing partners have to act in a timely manner (the right time) taking cognisance of emerging opportunities for innovation, and services quality improvement. The use of evidence-based strategic information and data should become the norm, and always putting people first becomes the strategic practice.

For this Road Map, the theory of change, has identified a number of areas where these oughts to happen as shown in the figure 3 below. A key consideration is what will trigger or cause change and where change should occur. In the case of Eswatini change will occur at planning, financing, implementation or service delivery, individual or at community and or at policy level.

Figure 3: Theory of Change



The first pre-requisite is to redefine our approaches of finding people who are at high risk and in need of high impact and precision HIV prevention interventions. Strategic information becomes a pre-requisite for both the service provider and beneficiary. Using strategic information to increase awareness and improve comprehensive knowledge of HIV and AIDS, and HIV prevention services is a fundamental strategic option. Available evidence shows that when people are aware and have comprehensive knowledge, access, utilisation and retention on service significantly improves. Personal risk perceptions also improve and individuals are able to navigate through avoiding harm's way. As demand creation improves, more people become engaged, ensuring that no one is left behind.

If the change has to be effective and meaningful, the change process has to start with the individual, and then the society where the individual live. Service packaging must move from generic service packages to targeted and differentiated packages that resonate with specific needs of the individual or a group of people, while being cognisance that environmental and societal factors have strong influence on individual behaviours.

The environment, in which services are being planned, financed, delivered, accessed and utilised needs to be transformed to make the environment socially and policy "enabling". This means that social, policy, human rights and legal barriers to access and utilisation of services must be addressed and removed in a systematic way. Negative social-cultural norms and practices that influence the spread of HIV needs urgent and timely attention through meaningful engagement and participation of all community leaders ranging from chiefs, royal kraal headmen, constituency leaders to local religious leader, and community members themselves. In most cases specific communities tolerate harmful socio-cultural practices because they are deep rooted in tradition and cultural practices. These can only be addressed through meaningful engagement and participation of all stakeholders concerned.

With regards to policies and laws, there are three dimensions of change that can effectively support HIV prevention. First, where there are no policies or law, and the need has been clearly identified – they should be urgently developed and disseminated. Second where they exist and are not being adhered to, effort should be made to ensure effective implementation and compliance. None compliance should not be an option at all. Third, where they exist and are no longer aligned to best practices or violate the rights of KVP, they should be urgently reviewed and reformed. Policy changes will demand intensive advocacy and communication, supported by evidence-based information and data. Stakeholders must approach this from a strategic partnership relationship avoiding fragmentation and segmentation of operational approaches.

Although human rights are universal and demand collective protection, respect and fulfilment, violations continue to occur mainly due to structural and behavioural (including moral and religious) factors and practices. Most human rights violations are based on political, social/moral or religious beliefs and hence difficult but not impossible to address. The need to influence change in our beliefs and political positions is urgent now than ever before if we have to end AIDS as a public threat in Eswatini by 2025. This is possible when we use evidence-based information and data to support the need for change. Currently the use of strategic information to influence strategic changes in HIV prevention is sub-optimal.

Eswatini has to change from vertical HIV prevention approaches to integrated population-based and driven responses, from one-fit- all approach to regional specific response that address regional specific challenges and needs – including localised epidemic drivers. Generic approaches are not yielding the

desired results. Hence the need to change and adopt combination prevention, coupled with precision prevention that resonate to the specific and individualised needs. Prevention approaches must recognise that while sub populations have some commonalities, individual needs are more likely to be different and hence packaging interventions based on the combination prevention approach must take into consideration the sub population and individual needs. Prioritised services must be age appropriate, gender sensitive and responsive, and are premised on human rights principles. HIV prevention service delivery approaches must create pathways for meaningful engagement and participation by beneficiary.

Moving beyond HIV combination prevention to precision and individually targeted interventions / approach has several strategic benefits. It is cost efficient, reduces beneficiary fatigue arising from vertical approaches, strengthens synergy and effectiveness, promotes and supports adherence and retention. It is imperative that service providers change and adopt more efficient and effective service delivery practices that are evidence-informed, apply best practices and innovative technologies.

HIV prevention continues to be underfunded. Treatment continue to receive the large share of both domestic and external funding. While treatment contributes significantly to HIV prevention through ART, this is a reactionary approach. Stopping new infections in the first place is a better option rather than waiting for infection to occur and then treat. Investing adequately and sustainably in HIV prevention is urgently needed. This will demand changes in the way decision are made and resource allocated.

Although communities are the cornerstones for HIV prevention, their engagement has remained symbolic. More than often their participation has been for purposes of donor “compliance”. If HIV prevention response has to attain its optimal level, communities and in particular KVP have to be empowered to become strategic partners and not be seen as service beneficiaries only. Meaningful community engagement and participation would improve service access, delivery, utilisation, adherence and retention of the target population.

Finally strengthening coordination, leadership, governance and accountability of HIV prevention at all levels is a primary requirement for HIV prevention success. Current fragmentation, and weak coordination and accountability mechanisms will remain a significant barrier to achieve the desired HIV prevention results.

1.6 Alignment with Other National and Global Policy Frameworks

The HIV Prevention 2025 Road Map interventions have been aligned to the following national and global Policy frameworks

National Policy Documents[3]

a) National HIV Prevention Policy 2019 (NERCHA, 2019)
b) National Multi-sectoral HIV and AIDS Strategic Framework 2024 – 2027 (draft)
c) National Health Sector Strategic Plan 2024 – 2027 (draft).
d) National HIV and AIDS Multisectoral Response Coordination, and Accountability Framework 2023 - 2027,

[3] Note: National Multi-sectoral HIV and AIDS Strategic Framework 2024 – 2027 and the National Health Sector Strategic Plan 2023 – 2027 are currently being developed, and are expected to be finalised by September 2023.

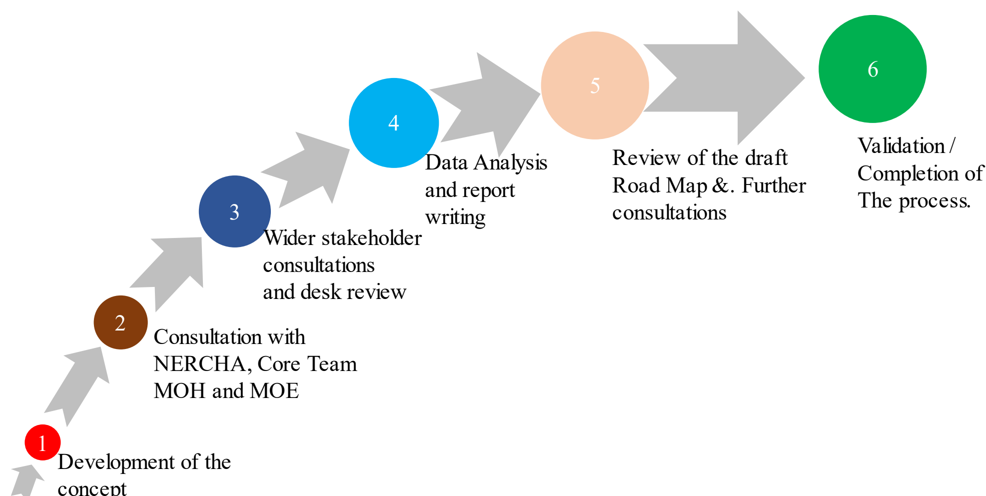
Global Policy Documents

- Global HIV Prevention Road Map 2025 (Global HIV Prevention Coalition)
- End Inequalities, End AIDS: Global AIDS Strategy 2021-206 (UNAIDS 2021)
- Sustainable Development Goals, (United Nations 2015)
- Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS. By 2030, (United Nations - June 2021)

1.7 The Process of Developing the Road Map

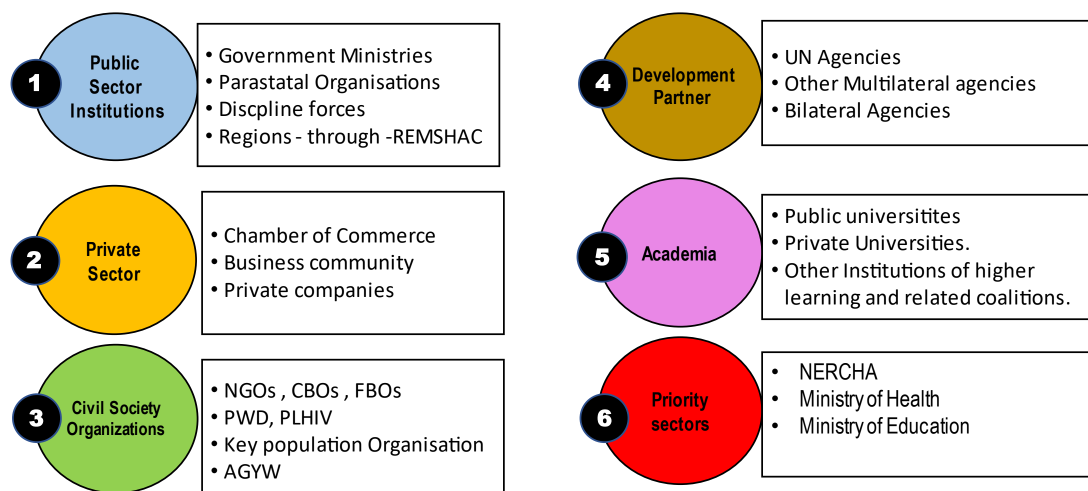
The process of developing the road map was participatory and provided opportunities for stakeholder's meaningful engagement and involvement at community, regional and national levels through the stakeholder consultations ranging from face to face and online key informant interviews and focus group discussions. The consultations were complemented by a comprehensive and in-depth literature review. The process is illustrated by the diagram below

Figure 4: Road Map Development Process



The consultations involved a wide range of stakeholders at national and regional levels representing different sectors shown in figure 5, below. NERCHA, Ministry of Health and Ministry of Education and Training were specifically targeted due to their strategic involvement in HIV prevention programmes.

Figure 5: Stakeholders Consulted



A total of 287 people participated in the stakeholder consultations – (KII, FGD). 67 KII were conducted with programme staff and managers and selected development partners, 16 people represented the HIV prevention TWG, 6 were drawn from the high level Steering committee, and 198, people participated in FGD at regional, national, and sector levels

Section 2: HIV and AIDS: Epidemiological Analysis

The main modes of HIV transmission in Eswatini are heterosexual accounting for 94% (2018) of all new infections and mother to child transmission (MTCT). Some infections were reported to have occurred as a result of accidental infections in health facilities and from people who inject drugs (PWID) using contaminated needles. Despite the high increase of GBV cases including rape, there is no conclusive empirical data on the contribution of GBV to new HIV infections. However, during the regional stakeholder consultations service providers suggested that some infections could have occurred as a result of sexual abuse.

Eswatini has a generalised epidemic with pockets of concentrated epidemic among key and vulnerable populations. The epidemic is rapidly spreading along the fault lines of social economic and political developments associated with social, gender and economic inequalities.

Note: *The primary source of information and data used in the following section a combination from the Estimates and projections (2022), SHIMS 3 (2022), and the Joint Programme Review TB/ HIV PMTCT report (2023). Additional information is from other sources as indicated.*

a) HIV Incidence (and New Infections)

- SHIMS 3, (2021) has estimated annual incidence of people 15 years and above at 0.62%, translating to 4000 new infections annually. Data analysis show HIV incidence among women, 15-49 at 1.45% and that of men at 0.20%. Incidence for women and men 15 years and above is estimated at 1.11% and 0.17% respectively. HIV incidence among people 15 years and above was

higher in women (1.70%) than in men (1.02%). It was also higher among AGYW aged 15-24 years, estimated at 1.87% for females and 0.79% for males. For people aged 15-49 years incidence was estimated at 1.49% in 2021 and is expected to decline to 1.44% by 2024.[4] Between 2011 and 2016, incidence declined from 2.48% in 2011 to 1.39% in 2016 (SHIMS 2- 2016-2017). The data also shows a decline for people 15 years and above from 2.1% in 2017, and to 1.37% in 2021. This has been projected to decline further to 1.35% in 2024. Incidence remains higher in women (2.03%) than in men (0.83%)[5].

Table 3: Incidence by region and sex: Adults 15 years and above

Region	Total	Male	Female
Hhohho	1.25	0.77	1.87
Lubombo	1.55	0.94	2.32
Manzini	1.38	0.85	2.03
Shiselweni	1.04	0.57	1.57

Source: Estimates and Projections Report , UNAIDS, 2022

- For young people 17-24 years incidence declined for both to 1.49% in 2021. It remained higher in women (1.75%) aged 15-24 years than in men (0.31%). This is two times higher among compared to their male (0.79%) counterparts. This is projected to increase in 2024. Incidence for AGYW 15-24 years is estimated at 1.87%. AGYW account for 82% of new infections.

Table 4: HIV incidence by region and sex – Adolescents and young people 15-24yrs

Region	Total	Male	Female
Hhohho	0.96	0.30	1.72
Lubombo	1.20	0.36	2.16
Manzini	1.08	0.33	1.89
Shiselweni	0.82	0.24	1.50

Source: Estimates and Projections Report , UNAIDS, 2022

- Incidence is higher among amongst women than men. New infections are expected to increase by 6.7% among females compared to 5.3% among males. However, new infections for all people 15 years and above will increase from an estimated 6,971 in 2021 to 9988 by 2024. In the case for adolescent women and young adults aged 15-24 years (2236) new infections will increase to around 2339 in 2024[6].

[4] Estimates and Projections 2022, UNAIDS
[5] SHIMS 3, (2021)
[6] Estimates and Projections 2022, UNAIDS

- The current ration of incidence to prevalence (IPR) is estimated at 2.7. A ratio of below 3.0% is often an indication of that the epidemic will decline over time.

b) HIV Prevalence

- In 2021, HIV prevalence among 15-49 was estimated at 27.9%. Prevalence was found to be higher among women (32.5%) than men (21.3%). HIV Prevalence peaked for women (35-39yrs) at 54.2% and for men (45-49yrs) at 48.8%. (Spectrum report 2022). HIV prevalence is anticipated to decline to 26.07% by 2024.In 2021, HIV prevalence for adults 15 years and above was estimated at 24.8% (SHIMS 3) (females: 30.4%), Males: 18.7%) in 2021[7].
- Prevalence among women was estimated at 30.8% has further estimated HIV prevalence among women aged 15-49 years at 31.6% and that for men at 15.6%. for both women and men 15 years and above prevalence has been estimated at 30.4% and 18.7% respectively. Prevalence is three times higher in women aged between 25 and 29 years, and girls between 20 and 24 years[8].
- Among adolescent and young people 15-24 years prevalence was estimated at 16.2% for females and 3.0% for males. Available evidence show that this age group is more likely to have low HIV testing, and hence low ART uptake.
- Prevalence varies with regions with Manzini having the highest at 27.93%, compared to Lubombo (27.20%), Hhohho (25.25%) and Shiselweni (24.89%)[9].
- HIV prevalence among MSM is estimated at 12.6%. Same sexual relationships in Eswatini are illegal and coupled with stigma and discrimination which continue to fuel new infections. In 2021, HIV prevalence among FSW was 58.8%, MSM 21.0%, transgender people 41.2% and in prisons HIV prevalence was found to be 33.8%. The review also noted that 12% of FSW and 34% of MSM don't know their HIV status[10].

c) People living with HIV (PLHIV)

- The population of PLHIV is estimated at 219,702 comprising of 212,528 adults 15 years and old and 7174 children between 0-14 year. The total population of PLHIV is expected to increase to 226,061 by 2024[11].
- Table 5, below indicates the population of PLHIV by region and sex. Manzini has the largest population followed by Hhohho. The number of women living with HIV is higher than men across all regions. 50% of women aged 35 – 49 are living with HIV.[12] The distribution of adolescents and young people 15-24 years follow the same pattern with Manzini having 7,026, Hhohho - 5288, Lubombo – 4195 and Shiselweni has 3773.[13]

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[7] HIV Estimates and Projections, 2022, UNAIDS
[8] HIV Estimates and Projections, 2022, UNAIDS
[9] HIV Estimates and Projections, 2022, UNAIDS
[10] SHIMS-3, 2021 MOH
[11] HIV Estimates and Projections, 2022, UNAIDS
[12] SHIMS-3, MOH 2021
[13] HIV Estimates and Projections, 2022 UNAIDS

Table 5: PLHIV by region and sex

Region	Population of PLHIV		
	Total	Male	Female
Hhohho	58,427	21,423	37,004
Lubombo	42,948	16,730	26,214
Manzini	78,214	28,440	49,766
Shiselweni	34,195	11,572	22,623

Source: Estimates and Projections Report , UNAIDS, 2022

d) Prevention of Mother to Child Transmission (PMTCT / eMTCT)

- The MTCT rate is estimated at 3.7% in 2021[14]. The rate at 6 weeks of age is estimated at 1.45% and is likely to increase to 2.25% by 2024.
- The final transmission rate (at the end of breastfeeding) is estimated at 3.14% in 2021 and will increase to 4.49% by 2024.
- The number of HIV positive pregnant women needing ART is projected to decline from 9181 in 2021 to 8089 in 2024.
- Between 2016-2018 a total of 9116 HIV positive pregnant women were enrolled on ART. During the same period 99% of HIV positive pregnant women received ART for PMTCT[15].
- The proportion of HIV exposed infants being tested for HIV within six weeks increased from a low of 43% in 2010 to 78% in 2018[16].

e) Antiretroviral Therapy (ART)

PLHIV can access ART from health facilities throughout the country. Despite the availability of HIV testing services and ART in the country, not all PLHIV are on ART.

- Eswatini was among the first countries in the world to achieve the 90-90-90 targets in 2017. By 2021, Eswatini surpassed the second (97%) and third (96%) of the 95-95-95 targets. Analysis of SHIMS 2021 data shows that for the first 95 target, Eswatini achieved 94% [17]. Viral suppression was found higher in women (92%) compared to men (83%) aged 15 years and above. Viral suppression was lower among young women 15-24 years at 76.1%, and men 25-34 years at 62.9%[18].
- Despite the improved coverage of ART, not all PLHIV are on AR – for example 13% of men living with HIV who know their status are not on ART[19].

[14] Estimates and Projections, 2022 UNAIDS
[15] SHIMS-3 2021, MOH
[16] Estimates and Projections, 2022 UNAIDS
[17] Data source: CHIMS 3 (2021), and Estimates and Projections (2022)
[18] SHIMS-3, 2021 MOH / and HIV Estimates and Projections Report 2022, UNAIDS
[19] Joint Programme TB/HIV/PMTCT report, MOH, 2023

- Table 6, below shows trend analysis of Eswatini performance in 90-90-90 and 95-95-95 cascades by sex between 2017 and 2021.

Table 6: 95-95-95 Cascade Analysis

Indicator	2017		2018		2021	
	Male	Female	Male	Female	Male	Female
PLHIV who have tested and know their HIV status	95	94	89	94	100	94
PLHIV diagnosed with HIV on ART	100	91	100	92	100	100
PLHIV who have achieved viral suppression	81	92	88	94	98	94

Source: Estimates and Projections Report , UNAIDS, 2022

Analysis of the data in table 6, show that adult women are doing better than men at 94%, 95% and 98% respectively. With regard to viral suppression women 15 years and above had better results (90.1%) than men (86.1%). However in the case of both women and men aged 15-49 years, viral suppression was estimated at 88.6% for women and 82.4% for men[20].

- Available SHIMS 3 (2021) data shows a viral suppression rate of 96.2%. Viral suppression in women (95.9%) was found to be higher than in men at 96.7%. SHIMS 3 data further shows marginal regional variations in viral suppression. Shiselweni has the highest viral suppression rate of 89.6%, followed by Hhohho with 89.0%, Lubombo – 88.9 and Manzini at 87.7% [21]

- SHIMS 3 data, estimated treatment coverage at 97.3%, with women (98.1%) doing better than men (95.9%). The greater challenge is among men aged between 25 and 34 years.

- ART coverage has significantly improved across all the four regions. It is also evident that the impact of ART is significant when measured against the survival rate of PLHIV, or number of deaths occurring due to AIDS. ART averted 8970 deaths in 2021. Deaths are lower in areas with good ART coverage.

[20] SHIMS 3 (2021), Summary sheet MOH
[21] SHIMS 3 (2021), MoH

Table 7: ART converge by region and sex.

Region	PLHIV Population on ART					
	Total	%	Male	%	Female	%
Hhohho	58036	90.8	19911	85.8	38125	93.8
Manzini	60863	91.7	20881	87.0	39982	94.4
Shisweleni	33657	76.5	11547	94.2	22110	97.8
Lubombo	40173	82.9	13782	75.2	26390	87.9

Source: Estimates and Projections Report , UNAIDS, 2022

f) AIDS related mortality

AIDS related mortality is expected to decline due to the expanded treatment eligibility criteria, using the "Test and Treat" approach. The "***incidence to mortality (ITM)***" ratio for Eswatini is estimated at 1.39 (spectrum 2022)[22].

- AIDS related deaths are projected to decline from 2418 in 2021 to 1907 in 2024. During that period AIDS related deaths will be higher among females compared to men. Women account for 59% of all AIDS related deaths.
- Among children 0-14, AIDS related deaths in 2021 were estimated at 152. The number is expected to decline from 152 in 2021 to 143 in 2024.
- The total number of orphans due to AIDS related deaths will decline from 57618 in 2021 to 43618 in 2024
- AIDS mortality increased from 2400 in 2020 among adults to 2418 in 2021 (spectrum 2021). Mortality among children decreased from 210 to 152. More women (1372) died of AIDS than men (1046)
- Table 8, shows AIDS related deaths by region and sex. Manzini region had the highest (768) deaths followed by Hhohho (728) and with Shiselweni with the least deaths (504). Manzini has also the highest population of PLHIV[23].

[22] HIV Estimates and Projections 2022, UNAIDS
[23] SHIMS-3, 2021 MOH / and Estimates and Projections Report 2022, UNAIDS

Table 8: AIDS related deaths by region and sex

Region	Population of PLHIV		
	Total	Male	Female
Hhohho	728	315	413
Manzini	764	330	433
Shisweleni	422	183	240
Lubombo	504	218	286

Source: Estimates and Projections Report , UNAIDS, 2022

g) Prevention of Mother to Child Transmission (PMTCT)

- 94% of pregnant women know their HIV status, and 99% of them are on ART.
- 91% of all exposed children have been tested for HIV. Testing is conducted at 6-8 weeks; 12 and 18 months. [24]
- The MTCT rate at 6 months and 18 months declined from 4.11% to 2.52% and 6.66 to 4.49% between 2017 and 2021. In 2018, MTCT rate at 6 months was estimated at 2% and by 2022, it had dropped to less than 1%.[25]
- A review of data on new infections due to MTCT show that infections will increase from 288 in 2021 to 363 in 2024. Similarly PMTC coverage will also decline from 99% to 95% during the same period.
- The number of pregnant and lactating women in need of ART declined between 2017 and 2021 from 10,640 to 9,200 respectively.[26] However ANC coverage is estimated at 92%.[27]
- It is estimated that AGYW contribute 33% of current new infections due to MTCT while 50% of MTCT are from HIV pregnant mothers tested at their first ANC visit.
- Coverage for syphilis testing of pregnant women remains low at 41%. And treatment seropositivity for pregnant women is estimated at 31%.
- Between 2017 and 2019 there was a gradual increase in PMTCT coverage, but that dropped by 12% in 2020 and increased again in 2021 increased significantly by 99%. Despite the progress, it is anticipated coverage will decline between 2022 and 2024. (Spectrum 2022) [28].

Table 9: PMTCT converge and new infections

	2017	2021	2024
PMTCT coverage	87%	99%	95%
New Infections	709	288	363

Source: Estimates and Projections Report, 2022

[24] HIV Estimates and Projections Report 2022 / and SHIMS-3, 2021
[25] HIV Estimates and Projections Report 2022 / and SHIMS-3, 2021
[26] Joint Programme TB/HIV/PMTCT report, MOH, 2023
[27] HIV Estimates and Projections Report 2022 / and SHIMS-3, 2021
[28] Joint Programme TB/HIV/PMTCT report, MOH, 2023

h) Other Epidemiological Analysis

- **Tuberculosis (TB):** According to the Joint programme review report, 98% of PLHIV with TB/HIV co-infection were receiving ART. TB case detection has remained low. As result 53% of cases are missed. TB mortality remain high especially in DS-TB at 13% compared to DR-TB with 10%. TB incidence rate per 100,000 population was estimated to be 62% in 2023[29]. However RR/MDR-TB treatment success rate is estimated at 92%. In 2021, young people aged 15-24 years accounted for 12% of notified TB cases. People between 25 and 44 years accounted for 51.7% of the cases. TB prevalence is higher in males than in women especially those aged 35 years and above[30].
- **Orphans:** In 2020, Eswatini estimated the number of AIDS orphans (boys and girls) was at 53 000 and 11000 (0-14 years) were living with HIV by 2018. Of these 76% were on ART. However new infections and AIDS related death has reduced to less than 1000[31] .
- **Men and Boys:** 50% of men living with HIV know their HIV status and 68% are on treatment.[32] Approximately 62% of them are said to virally suppressed. By 2018, 35% of men aged 15-49 years and above reported having been circumcised. Of these 29% were aged 15-24 years while 17% were 25 years and above[33]

2.1 HIV Epidemic Driver

There are multiple layers of drivers of the HIV epidemic ranging from the proximal drivers such as multiple and concurrent partnerships through to the more distal drivers such as patterns of migrant labour. These drivers are exacerbated by a number of underlying factors, including cultural and traditional practices and gender norms, social and economic inequalities. In some instances the problem is compounded by inappropriate policies and laws that hinders access to prevention services. Unless these barriers are systematically addressed HIV and AIDS will remain a public health threat. The following have been identified as the behavioural, biological and structural drivers of the epidemic in Eswatini.

Table 10: HIV risk factors among AGYW and their partners

Biological	Behavioural	Structural
• Biological susceptibility of women and AGYW • High viral load among male partners • Low prevalence of safe male circumcision (SMC) • Other untreated STIs	• Age-disparate sex • Sex work and sexual exploitation • Transactional sex • Early sexual debut • Gaps in comprehensive knowledge of HIV and AIDS • Limited personal risk perception • Inadequate and inconsistent condom use	• Gender inequality • Harmful social and gender norms such as early marriage and polygamy • Low secondary school entrance and completion particularly of girls • Poverty - leading to school dropouts

[29] Joint Programme TB/HIV/PMTCT Review report, MOH, 2023
[30] Joint Programme TB/HIV/PMTCT Review report, MOH, 2023
[31] HIV Estimates and Projections Report 2022 / and SHIMS-3, 2021
[32] Men engagement in HIV testing treatment and Prevention in ESA - Factsheet
[33] Joint programme TB/HIV/PMTCT review report, MOH, 2023

	• Forced sex / sexual exploitation and rape • Unplanned or unwanted pregnancies • Infection with other STIs, other than HIV	• Low economic empowerment of women • Labour migration and spousal separation • Orphanhood due to AIDS and other causes. • Child sexual abuse, • Gender-based violence / and intimate partner violence • Early marriages • Legal and policy barriers • Stigma and discrimination

2.2 HIV Prevention Strategic Gaps and Challenges

The following are the cross cutting strategic barriers to HIV prevention. In most cases they intersect and compound each other making it difficult to singularly address them, hence the need to adopt the combination approach, where different interventions create significant synergy and impact. The analysis of these cross-cutting gaps and the population specific gaps have informed the articulation of the strategic directions in Section 3.

Table 11: Gaps/Challenges, Strategies and Proposed Action

Gaps /Barrier	Strategies	Proposed action
2.2.1: **Accountability and Leadership Barriers**: • Accountability for HIV prevention remain low, weak and inadequate. Duty bearers more than often do not take accountability seriously. This is compounded by disrespect and violations of human rights. While political commitment is verbalised, actions to ensure compliance and accountability are lacking. • Eswatini does not have a common health and human rights accountability framework to hold service providers accountable. • Coordination is fragmented, coordination structures are weak, lack resources, and effective authority to execute their mandate. At programme level coordination is vertical, and in some instances coordination structures are located in different institutional departments and don't necessarily talk to each other • Too many un coordinated and fragmented thematic and sector coordination structures – including multiple technical working groups (TWGs). • Limited political leadership in HIV prevention • Inadequate funding for coordination activities	• Strengthening HIV prevention coordination, leadership and accountability. • Alignment of the framework with other policy documents such as the National HIV Prevention Policy (2019), the National Strategic Framework for HIV (2023 - 2027) and related global instruments and policies. • Intensifying advocate to galvanise and strengthen political commitment and leadership for HIV prevention. • Intensifying the multisectoral and decentralised engagement with other stakeholders.	• Develop and disseminate the National Coordination and Accountability Framework • Train all service provider and leaders on accountability strategies. • Strengthen the capacity of national coordination structures to support HIV prevention accountability.

• Some sectors are not prioritising HIV/AIDS response resulting in a drop in the ladder, as reflected in decision making, policies and resource allocation and even in the integration process.		

2.2.2: **Human Rights, Policy and Legal barriers**: Harmful or punitive policies and laws, and violations of human rights have been identified as critical barriers to HIV prevention. The problem revolves around lack of policies or laws, poor implementation, enforcement and inadequate compliance and in some cases lack of awareness and knowledge of such instruments where they exist. GBV is a common occurrence of human rights violation and key barrier to access services for girls and women. GBV is equally reinforced by negative pre-existing social, cultural and economic inequalities between men and women
 	
HIV prevention commodities are not readily available all the time when needed (i.e. condoms, PrEP, PEP, FP contraceptives etc)
 	
Criminalization of key populations exposes them to risky behaviour and violence.
	• Intensify advocacy to strengthen the social, policy and legal enabling environment and in particular advocate to remove all forms policy and legal bottlenecks.
	• Intensify advocacy to influence policy reviews and law reforms to support an enabling environment
	• Promote the use of the human-rights approaches to planning and programming HIV prevention activities.
	• Undertake strategic litigation to influence systemic changes where opportunity arises.
	• Advocacy to address the criminalization of and discrimination of key and vulnerable populations
	• Intensify advocacy to harmonise current policy instruments that are in conflict or are contrary to global best practices
		• Review and reform policies and laws and develop new policies where there are gaps Examples:
		  • Provision of condoms in schools
		  • Policies / laws are barriers to provision of clean needles and syringes to PWID
		  • Policies / laws related to criminalisation of same sex relationships
		  • Laws that are being used to harass sex workers
		  • Policies that hinder provision of services to key populations
		  • Conflicting policies especially on the age of consent for HIV testing – needs review and harmonising with other legal provisions[34]
		• Train service providers in human rights approach to HIV programming
		• Conduct legal literacy campaigns at all levels.
		• Review and update technical guidelines and protocols / SOPs to support a human rights-based HIV prevention.

[34] For the conflict between the MOH National ARV and PrEP guideless, the Children's Protection and Welfare Act of 2012.

		• Provide legal aid.
2.2.3:**Stigma and discrimination:** Stigma and discrimination remains the single most significant social challenge to access and utilisation of services affecting KVP. Stigma related to HIV was compound by COVID-19 and also fuelled by fear and service provider attitudes. Policies and laws prohibiting stigma or discrimination are poorly implemented or enforced.	• Intensify community led awareness and advocacy against stigma and discrimination • Train service providers on stigma and discrimination reduction strategies, including awareness and education. • Enforce implementation and compliance with policies and legislation on stigma and discrimination reduction, and improve accountability. • Strengthen community led monitoring of HIV prevention services and programs	• Implement the recommendations of the Eswatini stigma index report and practice stigma reduction. • Conduct social and community mobilisation to galvanise support to reduce HIV and COVID 19 stigma and eliminate discrimination. • Train peer educator and community health workers on stigma reduction strategies. • Monitor duty bearers' performance in enforcing stigma and discrimination reduction policies.
2.2.4: **Social and Economic Inequalities (including gender**): Inequalities are driving the HIV and AIDS along the fault lines of social-economic and political development. They increase risks and vulnerabilities of KVP. They are not only a threat to economic and social rights but also threatens the realization of all forms of rights and national security.	• Identify, prioritize and address socio-economic inequalities influencing HIV infections most. • Invest smartly and adequately in programmes targeting social and economic inequalities.	• Create awareness of inequalities and their implications on HIV prevention. • Strengthen community-based interventions to end social-economic inequalities affecting both in and out of school AGYW and AYBM. • Address gender-based power relationships that often lead to GBV and other forms of abuse for women or vulnerable populations. • Empower KVP to initiate community-based programmes that address inequalities. • Intensify advocacy for social protection of KVP.
2.2.5: GBV/IPV: Gender-Based Violence (physical, sexual, emotional and IPV) put people at a higher risk or make them more vulnerable. These practices are reinforced by negative pre-existing social, cultural and economic inequalities between men and women. Cases of GBV are often lost due	• Intensify advocacy to influence compliance and implementation of relevant statutory instruments and policies for preventing GBV/IPV and providing care and support for survivors. • Improved referral to other services	• Conduct training for service providers on GBV reduction strategies • Provide safe places for GBV survivors • Provide legal aid.

to poor and inadequate evidence preservation. There are also significant challenges in post rape case management		• Strengthen national campaigns and education of Sexual Offences and Domestic Violence (SODV) Act 2018. • Establish SODVA offenders' registers in all Courts country wide including Magistrate Courts.
2.2.6: Ending Inequalities (including gender): There is mounting concerns about the persistence of different types of inequalities across multiple forms and dimensions that are driving HIV and AIDS, along the fault lines of social-economic and political development. They increase risks and vulnerabilities of KVP. They are not only a threat to economic and social rights but also threatens the realization of all other forms of rights and national security. Inequalities can be found based on gender, gender identity, sexual orientation, disability income, education, occupation, location, migratory status, and incarceration. Many of the inequalities intersect to compound each other.	• Intensifying integration and implementation of inequalities reduction in all social-economic, and cultural development initiatives. • Promote smart and sustainable investments in programmes targeting social and economic inequalities**.**	• Create awareness of inequalities and their implications on HIV prevention. • Strengthen community-based interventions to end inequalities, such as poverty, lack of access to education for girls, Gender-based power relationships • Empower KVP to initiate community-based programmes that address inequalities. • Intensify advocacy for social protection of KVP.
2.2.7:Inadequate dissemination of strategic information Although people are aware of health and human rights, they lack comprehensive knowledge and hence are unable to claim or assert their rights. Information is provided in an ad hoc manner and most often packages are presented in formats that are not beneficiary friendly. In some instances information is inconsistent, and communication channels are not targeted or are inappropriate for certain population group. Poor funding and inadequate implementation of SBCC / IEC interventions especially among young people . Inadequate implementation of CSE, and provision of life skills and SBCC campaigns in tertiary education institutions.	• Intensify advocacy on the use of strategic information to influence awareness and knowledge of health and human rights, catalyse behaviour change, trigger actions and galvanise community of practice for human rights. • Intensify human rights research and documentation of best practices. • Intensify human rights information dissemination through multiple and targeted channels.	• Operationalise the HIV prevention community of practice. • Establish and maintain social media platforms e.g. Facebook page and WhatsApp platform. • Develop targeted and user-friendly IEC materials - factsheets, policy briefs, posters brochure, video clips etc. • Develop and keep updated website. • Develop a virtual Human Rights Information Resource centre.

Low HIV prevention knowledge amongst youth (in/out) of school	• Promote and sstrengthen of HIV prevention education and SBCC programmes and messaging for youth in and out of schools. • Strengthening of HIV prevention campaigns at tertiary. • Strengthening of a human rights "community of practice".	• Improve Comprehensive sexuality education. • Develop a comprehensive SBCC outreach program for out of school youth. • Identify and strengthen partners support at tertiary education level to support and promote comprehensive HIV programmes

Table. 12: Population-based Gaps And challenge

KVP	Gaps / Challenges.	Strategy	Interventions
a) People Living With HIV	• Stigma and discrimination continue to be prevalent • They are often discriminated for social services because of their status • Adherence stigma.	• Implement the Positive Health Dignity and Prevention (PHDP) strategy, involving PLHIV • Implement the recommendations of Eswatini stigma index report. • Identify, test and link PLHIV who don't know their HIV status to treatment	• Implement the PHDP strategy • Conduct community mobilisation • Offer HTS and linkages to treatment • Implement Stigma Index report recommendations. • Improve access to services by discordant couples. • Strengthen HIV prevention peer led community-based interventions. • Operationalize the national advocacy strategy.
b) Lesbians, Gay, Bisexual, Transgender, and Intersex (LGBTI)	• Criminalisation of same sex relations. • Police harassment and arrests • Experience stigma and discrimination • Violation of the right to health • Limited education/sensitization on LGBTI • Poor access to services • Increased exposure to OI and STIs. • Exposure to physical violence, GBV, and rape	• Decriminalise KVP including FSW, MSM, PWID etc • Remove all forms of human rights, social, policy and legal barriers • Intensify advocacy to reduce stigma and discrimination • Strengthen the capacity of LGBTI organisation to deliver service	• Undertake and intensify advocacy and communication targeting policy and Law makers • Train services providers on human rights-based service delivery • Offer comprehensive integrate HIV services • Strengthen coordination of the KP programs

KVP	Gaps / Challenges.	Strategy	Interventions
	• Isolation of KVP based on moral values by some people or groups of people.		• Align KVP program M&E systems with national systems • Integrate KP friendly health services
c) Sex Workers (male and female)	• Experience GBV from clients. • Harassment from law enforcement officers • Rejection by community on moral grounds • High HIV prevalence	• Addressing all forms of human rights, social policy and legal barriers • Intensify advocacy to reduce stigma and discrimination	• Intensify Human rights awareness and education, including social protection. Offer economic empowerment skills and activities
d) Prisoners / Inmates	• Violation of their right to health • Inadequate access to health services in particular HIV prevention services. • lack of an integration strategy with communities after being released	• Improve and ensure access to a comprehensive package of services • Develop a post – prison strategy for prisoners integration in back in the communities. • Advocate for provision of condoms and lubricants to prisoners.	• Intensify awareness and education on prisoners human rights. • Offer HTS, ART, condoms, PSS, VMMC and PrEP/PEP services.
e) People who Inject Drugs	• Sharing of injecting equipment / risk of contamination • Unfriendly policy and legal environment leading to criminalization of injecting drugs / or drug use	• Strengthen the policy and legal environment to allow adequate planning and service delivery • Intensify SBCC • Prioritise the provision of clean needles and syringes / through the Opioid Substitution Therapy (OST) programme[35]	• Conduct SBCC outreach / and peer education • Conduct social mobilization • Offer risk reduction counselling and HTC; • Opioid substitution therapy (OST) and other drug dependence treatment, including ART for HIV, and PrEP

[35] OST is a process in which opioid-dependent injecting drug users are provided with long acting opioid agonist medications for a long period of time under medical supervision along with psycho-social intervention

KVP	Gaps / Challenges.	Strategy	Interventions
	• Sexual risky behaviours / i.e., unprotected sex given the influence of drugs • Poor service delivery – currently there are no dedicated services for PWID		• Offer STI Prevention and treatment • Condom distribution programs for people who inject drugs and their sexual partners
f) Miners (returnees)	• Violation of the health rights • Exposure to conditions that fuel TB infection / HIV infection • Un-guaranteed safety in the mines • Poor compliance with health rights and occupational guides that protect miners	• Intensify advocacy to promote compliance with comprehensive health conditions of miners.	• Intensify human rights-based awareness and education. • Advocate for improved access to health services • Provide legal aid • Enforce compliance to cross border agreements.
g) AGYW	• Poor access to HIV prevention services • Violation of rights. • Dis-empowered. • Gender -inequality with male partners • Unemployment. • Poor linkages to services • Attitudes of health care workers • Conflicting policy and legal guidelines on the age of consent for HIV testing, and HTS (12), sexual intercourse (16)[36]	• Scale up DREAMS for AGYW – especially out of school, • Ensuing availability of CSE to out of school youth. • Strengthening coordination community-based HIV prevention activities • Harmonise policies and laws and apply a human rights approach	• Intensify combination HIV prevention • Scale up DREAMS to other geographical areas. • Improve access to AGYW friendly services • Strengthen male engagement in HIV prevention programmes. For AGYW • Strengthen community led monitoring of AGYW interventions.

[36] The current policy and legal guidelines are not harmonized and hence provide conflicting messages especially on the age of consent for HIV testing. For example, "Section 2, Sub-Section 4.3.1 of the MOH for ART and PEP provides for PEP in the event of sexual abuse. A parent or guardian of a child below 18

KVP	Gaps / Challenges.	Strategy	Interventions
	• Inadequate parental guidance,		• Scale up social media platforms to reach AGYW with information. • Scale up "friendly" health services for KVP, AGYW and youth in general. • Strengthen partnerships with private to support HIV prevention activities. • Offer economic empowerment options
h) Young people i) .	• Low HIV prevention knowledge amongst youth (in/out) of school • Lack of sustained income leads to risk and vulnerabilities for youth contributing to transactional / intergenerational sex. • Delayed payment of scholarships increases vulnerabilities amongst tertiary institution going youth. • Inconsistent supply of condoms in tertiary institutions and rural communities.	• Intensifying availability and provision of CSE for both in and out of school youth. • Digital, online platforms to share HIV prevention massages to reach the youth.	• Re-designing of the MOH school's health program and upscale • Strengthen the provision and monitoring LSE implementation in schools –MoET • Advocate for LSE to be an examinable subject at levels of education. • Intensify condom promotion and distribution • Provide economic empowerment interventions.
j) Boys and Men	• Unemployment / including lack of appropriate migratory labour opportunities • Men tend to seek health care late. • Stigma and discrimination • Harmful social and cultural practices. • Criminalisation of MSM, male sex workers, and PWID	• Comprehensive sexuality education to be provided to out of school youth. • Intensify targeted out of health facilities HTS • Increase awareness and access to PrEP, and SMC • Intensify condom promotion and distribution	• Map out their areas/activities of interests- provide HIV services- social circles e.g. golf tournaments, music festivals, soccer social games, etc • Develop targeted interventions at workplaces • Increase community-based service outlets for men and boys

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years of age is expected to provide consent to an HIV test. This provision is in conflict with the testing guidelines and the Children's Protection and Welfare Act of 2012 which allows a child of 12 years to consent to HIV testing?

KVP	Gaps / Challenges.	Strategy	Interventions
	• Address gender inequality affecting men and boys. • Attitudes of health care workers		• Develop social media platforms for disseminating SBCC • Establish role models and roll out the "one men can" campaign.
k) People with Disability	• Lack of policy guidelines to guide HIV services to PWD. • Inadequate coordination of services • Violations of human rights - abuse, stigma and discrimination. • Lack of differentiated services for people living with disabilities	• Support development of a rights based national policy • Intensify education and awareness • Improve social protection. • Coordination and governance of national organizations working with PWD- FODSWA.	• Intensify advocacy and communication to galvanise support for PWD • Intensify SBCC • Provide legal aid • Design appropriate HIV prevention messages for PWD – with large fonts, brail etc.

Section. 3: Strategic Directions and Orientations

Strategic Policy Directions

The implementation of the HIV Prevention 2025 Road Map will be multisectoral and decentralised, creating meaningful opportunities for engagement and participation by diverse stakeholders based on their mandate, comparative advantage, capacity and resources. Implementation will occur at national, regional and at Tinkhundla.

The development of the Road Map is informed by the analysis of strategic barriers, gaps and challenges that prevent HIV prevention presented in Section 2. The understanding of these barriers, drives the question "what needs to be done to remove all forms of barriers that prevent HIV prevention? Answers to this question inform the articulation of the strategic policy and programmatic directions for the next phase of HIV prevention in Eswatini.

The lessons learnt from the past and analysis of best practices indicate that no single intervention or strategy will stop the spread of the epidemic, or reverse the impact of the epidemic. To have significant impact HIV prevention programmes, will require innovation, application of best practices, adaptation of new technologies, improved ways of service delivery, efficiency in coordination and in monitoring progress. Accountability for HIV prevention demands clarity of roles and mandate, and commitment by both service providers and intended beneficiaries

HIV prevention programming has to adopt the combination prevention approach that integrates biomedical, structural and behavioural interventions, given that the epidemic is being fuelled by socio-economic inequalities along the fault lines of social, economic and political development. Human rights, policy and legal barriers play a significant role in preventing access to HIV prevention services especially by KVP. This is compounded by inadequate awareness and knowledge not only of the epidemic itself, but also of related prevention services available not to mention the fragmentation and verticalization of service delivery.

The Road Map is intended to move HIV prevention beyond the combination prevention to precision and targeted services focusing on specific individual or sub population needs. The "precision" approach takes cognisance of the general sub population needs for HIV preventions but also recognise that individuals may have unique needs. This is particularly the case for key populations, women and AGYW. If these special needs are not adequately addressed may compromise the efficacy of prioritised combination prevention interventions.

The Road Map is designed to ensure that services are available, accessible and are being utilised to the optimum. To achieve this goal demands systematic scaling up, accelerating and intensifying implementation, coupled with effective and efficient coordination and efficient coordination and stakeholder's accountability. It will also require concerted multisectoral and decentralised commitment to address "all the barriers preventing HIV prevention". The HIV service providers must change their mindset from "what we want to do" to "what needs to be done" to achieve the right prevention results. They must do the right things, at the right time, at the right place in the desired scale and intensity, targeting the appropriate key and vulnerable population. This approach will revolutionise HIV prevention, infuse

innovative technologies and proven best practices. They will strengthen a robust coordination, accountability and leadership mechanisms that will put people at the centre of the prevention response.

The revolution will move the HIV prevention response from a national approach to regional focus that enables regions to address regional specific needs and challenges. Behavioural interventions will address risky behaviours, while biomedical interventions will aim at preventing new infections or reduce infectiousness. Structural interventions will be implemented to address the social-economic contexts that influence HIV vulnerability and risk. Interventions will be age appropriate, gender and human rights sensitive and responsive.

The proposed strategic directions and orientations will inform and guide Eswatini in developing operational strategies to address the identified gaps and challenges affecting the HIV prevention response. The strategic directions will seek to catalyse and revolutionise HIV response in a systematic way in addition to ensuring the quality of services. .

The following table articulates the key strategic directions for the national multisectoral and decentralised HIV prevention response.

Table 13: Road Map Strategic Directions

	Strategic Direction	**Description**
1	Precision and combination HIV prevention	Eswatini will promote the implementation of combination prevention approach, coupled with precision interventions. The precision approach will allow the layering of specific interventions at individual level to address specific (precise) needs, while ensuring that other prioritised HIV prevention packages are equally available and accessible to the individual or sub population group. The combination HIV prevention will enhance appropriate packaging of HIV preventions interventions, for specific sub populations with a mix of biomedical, structural and behavioural interventions. Service delivery modules will be differentiated to ensure that services resonate with the needs of the intended beneficiaries.
2	Stakeholder's Accountability	HIV prevention service providers will be held accountable for the services they offer and resources they use. Implementation of the national coordination, leadership and accountability framework will be intensified and compliance enforced. Eswatini will aim at making sure that 95% of people in need have access and use comprehensive HIV prevention services.
3	Ensure a people centred response.	Implementing partners will ensure that services are people centred and responsive to individual and community needs. The primary focus and targeting will be populations at higher risk, high disease geographical locations and ensure meaningful community engagement and participation.
4	Address strategic human rights, policy and legal barriers	Concerted effort will be made to remove all forms of human rights, social, policy and legal barriers to access to HIV prevention services. Unless the underlying barriers, social, cultural, gender and economic inequalities, determinants of risk and vulnerability to HIV are systematically addressed and removed prevention will not happen.

5	Multisectoral. Response	The multisectoral approach will be strengthened to leverage the participation and contribution of all sectors to HIV prevention based on their mandate and comparative advantage. The multisectoral approach will expand coverage and outreach.
6	Innovation and new Technologies	Eswatini will rapidly scale up and accelerate adaptation and implementation of innovative HIV prevention approaches and technologies such as scaling up of PrEP
7	Coordination, leadership and governance	Eswatini will strengthen and improve HIV prevention coordination, good governance and galvanising bold leadership at all levels of the response. Policies and legislations will be reviewed and improved. The implementation of the National Coordination, leadership and accountability framework will be intensified.
8	Community empowering communities	Communities will be capacitated to undertake community-based and community led HIV prevention strategies. It is anticipated that by 2025, communities will deliver 80%[37] of services targeting key populations.
9	Strategic information management.	Eswatini will ensure that HIV prevention programmes will be evidence based and data driven. Capacity to use strategic information and data will be strengthened.
10	Sustainability of HIV prevention programmes	The Government will develop and implement sustainability strategies that will including increase domestic funding for HIV prevention and reduction of donor dependence. Advocacy will be intensified to improve and support community ownership of prevention programmes.

1.8 Targets and Commitments

Figure 6, below illustrates that it is possible to achieve ambitious targets, if well planned, targeted, with sustained investment and sound implementation strategies and capacities. The Government of Eswatini is committed to achieve ambitious targets, including reducing HIV incidence to less than 0.4%. By 2025, eliminating MTCT, 95% of people at high risk of HIV infections will have access and will be using comprehensive packages of combination prevention. All people will be on board and no one will be left behind. A key commitment for Eswatini to achieve the 95-95-95 target at different sub population levels. The following table illustrates some ambitious targets to be achieved by 2025.

Table 14: Impact / Outcome Indicators and targets

	Indicator description	**Target (2025)**
1.	HIV incidence rate among people aged15-49 reduced	<0.4%
2.	HIV incidence rate among people aged 15-24 reduced	<0.4%
3.	% of infected infants aged 18-24months who are born to HIV positive mothers reduced	<0.1%

[37] This is the new target for community-led service delivery of HIV prevention in the 2021 UN Political declaration and in the Global AIDS Strategy 2021-2026. It is anticipated that the HIV prevention services for key populations will be delivered by key population-led organizations in collaboration with other community based organisations

3.	New HIV infections reduced	75%
4.	Number of new infections among AGYW (15-24 Years) reduced	50%
5.	Number of new infections among Key Populations – FSW, MSM, TG and inmates (prisoners)	50%
6.	95-95-95% HIV testing, treatment and Viral suppression achieved at sub population level (disaggregated by sub population, gender and age)	95-95-95
7.	% of PLHIV and Key populations experience stigma and discrimination	<10%
8.	% of PLHIV and key population experience gender-based inequalities and GBV	10%
9.	HIV Prevention is sustainably funded from both domestic and external funding	100%
10	All policy, legal and human rights barriers to HIV prevention addressed and removed	100%

1.9 Priority Target Population

The road map has prioritised Key and vulnerable populations. The prioritised key populations include LGBTI, female sex workers (FSW), PWID , and prisoners. The vulnerable populations include AGYW, ABYM, migrant workers and people with disability (PWD). It is evident that all key and vulnerable population remain at a higher risks of HIV infection some are at more risk or are more vulnerable.

The HIV epidemic in Eswatini has a gender bias with women affected more than men. Although women are not prioritised by the ESwatini or the Global HIV Prevention 2025 Road Map, Eswatini, will not only sustain but also accelerate implementation of targeted interventions for women who are socially and economically vulnerable. Women will also access services, being sexual partners for men addressed in pillar 3 of the Eswatini Road Map. Community-based women led organisations will be capacitated to take lead in such targeted interventions.

Premised on combination prevention, services will be packaged to resonate with needs of the individual person or group of people based on age, gender, social characteristics, and geographical locations among other criteria. For all populations groups advocacy and communication, social and behaviour change communication, social and community mobilisation will be integral components of their response.

Section 4: Prioritised High Impact HIV Strategies and Programme

The Road map has prioritised high impact interventions necessary to halt new infections among the priority target groups. These interventions are complemented by cross cutting social and programmatic enablers. Implementation will be scaled up, accelerated and intensified to making services available, accessible and improve utilisation. Interventions will also create awareness and knowledge of the epidemic and the related available services, intensify demand creation, mobilise and galvanize communities to ensure meaningful engagement, participation and ownership.

Service delivery will be 'differentiated" to ensure relevant, adequacy, age appropriateness, adequate targeting, gender and human rights sensitivity and responsiveness. Services will be integrated and packaged appropriately in order to maximise synergy and complementarity, enhance efficiency and effectiveness, and reduce beneficiary fatigue usually created by vertical service delivery approaches.

The Road map strategies are people centred, resonate with people's needs, and facilitate access to friendly, non-stigmatising or non-discriminatory services. Accessing services should be convenient, seamless and easy to navigate especially for KVP. Implementing partners will use a human rights approach to ensure that services are available in sufficient quantities and quality to meet the needs of the target population. They will also address other determinants of access and retention such as food, water, adequate sanitation, access to health facilities, availability of competent services providers, essential drugs, commodities, and information.

Efforts will be made to ensure equitable distribution of services, accessibility, user-friendliness and affordability by KVP including AGYW, PLHIV, and those with mental health challenges. The planning process will ensure that services resonate and appeal to the intended beneficiaries, adhere to acceptable medical and social ethical standards. To improve trust and confidence between the service provider and beneficiary, service providers will maintain confidentiality with their clients wherever required.

Access to information on services, drugs and commodities will be key as the target population have the right to know, the right to seek, receive and use information concerning the services they receive.

Communities (including CBOs, FBOs and CSO) will be strengthened through social contracting to take lead in community-based and community led implementation of specific interventions. This is premised on the recognition that communities, community based and community led organisations are the backbone of HIV prevention programmes. They have significant influence on social-cultural, economic, and political development processes that directly or indirectly influence HIV prevention behaviours and practices. The UN General Assembly Political Declaration on HIV and AIDS in June 2021, recommended that 30% of selected HIV and AIDS interventions, especially bi-biomedical be community-based and community led.

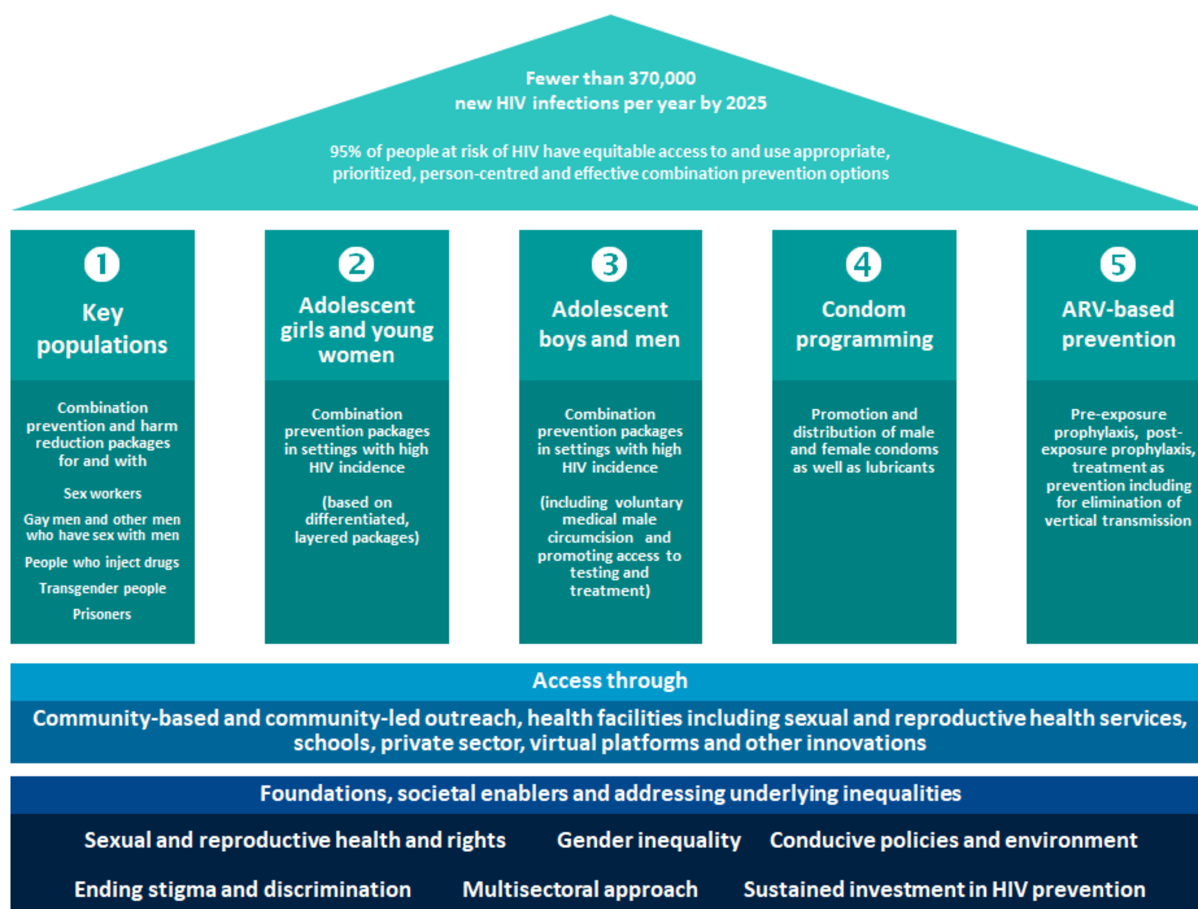
4.1 High Impact HIV Prevention Programmes

The HIV Prevention Road Map, is aligned with the Global HIV Prevention Road Map 2025. It is premised on the following priority HIV prevention five pillars

- Comprehensive HIV prevention for key populations,
- Combination prevention for AGYW,
- HIV prevention services for ABYM
- Condom promotion and distribution,
- ARV-based prevention – ART, PrEP, PEP, and PMTCT

While these interventions are distinct, they are complementary. Implementation is contextualised to the needs of Eswatini and local realities even at regional level.

Figure 6: Global HIV Prevention Road Pillars



Successful implementation of these pillars will equally depend on sustained investments, integration of service delivery platforms, the use of the multisectoral approach, the creation of enabling environments, and implementation of specific actions to reduce social-cultural and economic inequalities that impede HIV prevention. There is a strong focus on addressing policy and structural barriers that hinder access to prevention services, on ending stigma and discrimination, and on advancing gender equality. The Road Map have emphasised on the urgent need for improved coordination, accountability, and meaningful engagement and participation especially by KVP, target beneficiaries and their communities. The strategy ensures that nobody is left behind on HIV prevention.

The programmes are premised on the combination prevention approach, that embraces biomedical, behavioural and structural interventions. The structure of the interventions integrate cross-cutting strategies i.e. advocacy and communication, SBCC, social and community mobilisation. In all of the prioritised interventions, addressing human rights, social, policy and legal barriers will be an integral component. Services will be differentiated in order to ensure their relevance, strategic targeting, gender, age appropriateness and that they resonate to the needs of the targeted group.

4.2 The use of HIV Prevention Cascades

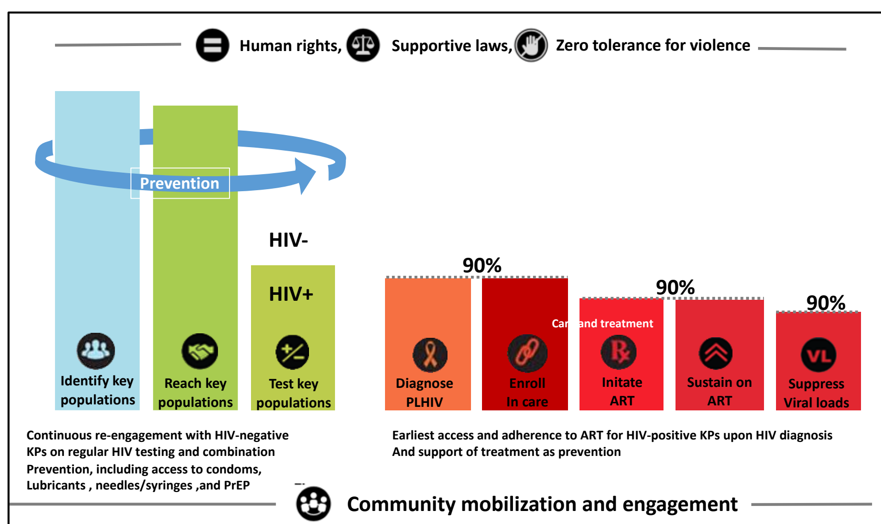
The planning and implementation of any of the Road Map interventions starts with the understanding what are the critical gaps and challenges in HIV prevention, what is working or not working to address these challenges, identifying who are the populations at higher risk, where theory live, and being able to analyse the risk factors. This understanding will enable implementing partners to adequately prioritise

specific actions and investment in any of the prevention pillars mentioned in figure 7, above. The planning process should be systematic paying attention to detail. Missing out on essential steps and or processes would suggest losses in beneficiary engagement, gaps in programme implementation and or services uptake that should be addressed.

Developing a HIV prevention cascade is challenging given the multiple interventions with different frequencies. Individual programme cascades will vary in their design, data requirement and sources, methods of measurements and hence interpretation of results. Based on available data, cascades are likely to be cross-sectional or longitudinal. While both are useful, the Road map suggest the use of cross-sectional cascades that are simpler and easy to use. They measure the different steps at a specific point in time and can provide a snapshot of the status of the HIV prevention programme across the population included in the HIV prevention cascade. However, longitudinal cascades are equally good as they track the same individuals (cohort) at each step of the cascade over time, allowing monitoring of the cohort's HIV prevention trajectory.

Cascades should clearly cite the population and prevention method included, the geographical area and time period covered and the data sources used. The information should also include clear definitions of what is being measured, the limitations in the data and the denominator used. Figure 8, below illustrates the continuum of HIV prevention, care and treatment cascade.

Figure 7: HIV Continuum of Prevention, Care and Treatment Cascade



Source: UNAIDS

4.2.1 Comprehensive services for Key Populations

Eswatini has defined its key populations to include LGBTI, MSM, FSW, PWID and inmates (prisoners). In 2020, key populations and their sexual partners accounted for 65% of HIV infections worldwide and 7% of these infections occurred in Sub Saharan Africa These groups are at a higher risk of HIV and more than often are marginalised, discriminated, stigmatised and exploited. Homosexuality, sex work and injecting drugs remains illegal and immoral practices. These circumstances make it difficult to adequately plan and provide services to the key populations. Retention and adherence to services is often compromised. Programmes or services targeting KVP have limited scale, scope, and intensity and or are often insufficient.

A critical objective of the Road Map is to intensify advocacy, SBCC, social and community mobilisation with the aim of removing all forms of human rights, social, policy and legal barriers to services experienced by KVP. Removing all barriers will improve availability of services, improve access and increase utilisation. Prioritised interventions will be scaled up, intensified and implementation accelerated. In particular SBCC will be scaled up to increase awareness and knowledge of the needs of key populations, in addition to making them aware of available services and their benefits at an individual and community level. Targeted SBCC will also contribute to intensifying demand creation for HIV prevention services.

Key population service providers will use the human rights approach to programming and in the implementation of the combination prevention approach. Efforts will be made to ensure that interventions are KVP centred, age and gender appropriate. As much as possible services should be community-based and key population led. At community level services for key populations are better delivered by trusted community-based organisations (CBOs) and or health facilities that are non-judgmental, accessible and competent in addressing key populations' needs on the continuum of prevention, testing and treatment services

The service packages will include but not limited to HTS, SBCC, social mobilisation, PrEP, PEP, PSS, legal aid, treatment of opportunistic infections, treatment of STIs and TB, and provision of condoms, lubricants, SMC, comprehensive harm reduction services for PWID and social protection.

M**en who have sex with men (MSM)** are considered as being among populations at high risk of HIV infections. It is also evident that some MSM also have sex with women creating an important epidemiological bridge to the general population. The main sexual risk factor is unprotected anal sex accounting for most HIV infections in MSM, aggravated by STIs. MSM are also exposed to stigma and discrimination associated with homosexuality. Social and economic issue affecting them include poverty, alcohol abuse, homophobia, and lack of access to health care. These are structural factors fuelling new infections among MSM.

*S*ex work is well established in Eswatini. **Sex workers** contribute significantly to HIV infections and in particular through their casual sexual partners. While sex work has become an occupation for some women especially those aged 25 years and above, for young women, sex work could in most cases be considered as "transactional" sex. Many of the young women are from poor households, unemployed, or from dysfunctional homes that make them vulnerable, put them at risk and are forced to engage in sex work. however, a focus on sex workers alone will not be sufficient to stop new HIV infections. It will require a comprehensive programme that targets the sex workers, their casual and regular sex partners. The Road Map advocates for accelerated provision of PrEP, condoms and lubricants, treatment of STIs, and access to comprehensive SRH services and rights. Sex workers also needs social protection against sexual and gender-based violence. Precision HIV prevention approach is considered a best practice especially when addressing the specific needs of individual AGYW below 19 years. For this age group offering HIV prevention interventions alone will not stop them from sex work, but layering HIV preventions with other interventions such as cash transfers or school subsidies, keeping girls in school will significantly reduce their vulnerability and risks to HIV.

In the case of **prisoners** the aim is to increase and improve access to essential HIV prevention services. Inmates experience sexual relationships that expose them to HIV and other STI infections. While it is important to prevent HIV infections among inmates when they are in prison, it is equally important that prisoners leave prisons being HIV negative. When prisoners leave prison infected, they could provide a bridge between HIV transmission in prison and in the community at large. HIV prevention packages for prisoners could include but not limited to HTS, ART, Condoms, STI management, PrEP, PEP, referral, SBCC and PSS. Improving service delivery for inmates will require in the first instance, a review and reform of existing policies to create an enabling policy and legal environment. There is need to develop a strategy to support them after they are discharged.

People who inject drugs are among those with the least access to HIV prevention services, due to un-enabling policy environment, stigma, discrimination and being criminalised. The Road Map intends to support provision of comprehensive harm reduction services for **People Who Inject Drugs**. This will include provision or exchange of clean needles and syringes, and access to opioid substitution therapy. Access to services will be voluntary.

In Eswatini, HIV is spreading rapidly along the fault lines of social economic development. Many people are unemployed and have no decent livelihood. This has resulted in **migratory and mobile workers** especially in areas with large textile factories, large plantations and commercial farms. Mobility and migration have increased HIV risk and vulnerability especially among young people and women in particular. They also shape the distribution of the epidemic and the rate at which the epidemic spreads. Hence, mobility and migration are both individual and structural risk factors that needs to be addressed.

The higher risk and vulnerability associated with migrant or mobile workers is the likelihood of having multiple and concurrent sexual partners, poverty (low income) leading to sex work, transactional and inter-generation sex. The Road Map will prioritise addressing behavioural and structural drivers of the epidemic, promoting and intensifying HIV testing. These will require meaningful engagement and participation of other development sectors who have better comparative advantage.

The involvement and participation by **people living with HIV (PLHIV**) in HIV prevention is critical for two reasons. HIV can only be transmitted from an infected person to one who is not. Hence the commitment by PLHIV to prevent new infections is the beginning of halting start reversing the epidemic. However, PLHIV are the most stigmatised and discriminated individuals. Their human rights are violated with impunity. Access to services is often compromised by the attitudes of service providers. The road map supports strategies that will scale up and strengthen meaningful involvement and participation by PLHIV in HIV response. The Road map aims to support scaling up "treatment as prevention". In doing so community mobilisation will be intensified to identify PLHIV who do not know their HIV status, have them tested, enrolled and retained on treatment (ART), with the aim for them to achieve viral suppression. Medical science indicates that viral suppression could be a major breakthrough in HIV prevention based on the understanding that "un-detectable virus is un-transmissible and hence the concept "U=U".

Advocacy will be intensified to support the implementation of the "Positive Health, Dignity and Prevention (PHDP)" with emphasis on treatment cascade leading to viral suppression. To address the HIV prevention needs of individuals in discordant relationships, specific interventions such as PrEP and condoms will be intensified.

People with disabilities (PWD) have increased vulnerability and risks to HIV due to their varying disability conditions. In particular women and girls with disability are often at heightened risk of sexual abuse and exploitation. People with sight impairment or have intellectual disability are at extremely high risk. They are not only stigmatised and discriminated but also physically and sexually abused. Participation by PWD in HIV prevention has been limited to a family affair as they are often considered difficult to manage. The Road Map will pursue three strategies to address HIV prevention among PWD.

- Identification and strengthening of community-based organisations that are dedicated to working with PWD to ensure they have the capacity to deliver appropriate and targeted services.
- Intensifying advocacy, SBCC, social and community mobilisation to increase community support and improve differentiated service delivery.
- Strengthen the capacity of service providers to deliver quality, comprehensive and differentiated HIV prevention packages targeting PLHIV.

4.2.2 Combination Prevention for Adolescent Girls, Young Women and their male partners

AGYW are defined as girls and young women aged between 10 and 24 years. AGYW are disproportionately vulnerable due to prescribed gender and cultural norms, income inequality, gender-based violence and their biological make up.

In 2021, the HIV incidence of females aged 15-24 years was estimated at 1.75% compared to males at 0.31%.[38] Incidence among AGYW is expected to increase to 1.81% in 2024. For AGYW incidence was highest in Manzini (1.89%) and lowest in Shiselweni (1.50%). Table 4 (Page 19 above) above shows regional variation among young people between 15 and 24 years by gender. Table 15 below shows new infections in absolute numbers by year and gender.

Table 15: New Infections (absolute numbers) among AYP 15-24 years – Trend analysis

Sex	2017	2021	2023	2024
Total	3,417	2,236	2,023	2,339
Male	727	359	359	371
Female	2,690	1,848	1,848	1,968

Source: Estimates and Projections Report , UNAIDS, 2022

In 2022, Spectrum data further suggests that 31% of new infections come from young people 15-24 years. 82% of these infections were contributed by AGYW, while 18% come from their males in the same age group Table 16, below compares the trajectory of new infections among young people 15-24 years between 2017 and 2024. More infections are likely to come from females than males. And while significant progress has been made to provide HIV prevention services it is projected new infections will increase in 2024.

HIV Estimates and Projections (2022, UNAIDS) has projected HIV prevalence among females aged 15-24 years at 16.2% and males at 3%. The number of females aged 15-24 years living with HIV was

[38] SHIMS -3, 2021, MOH

estimated at 14,581. The largest population is in Manzini (5087) and Hhohho (3825)[39]. In 2020 AGYW aged between 15-24 accounted for 25% off all new infections in Sub Saharan Africa, despite representing only 10% of the total population (UNAIDS, 202O).

The HIV challenges facing AGYW are much deeper than issues of sexual relationships and are deeply rooted in cultural and socio-economic practices. AGYW lack comprehensive knowledge of HIV, have poor risk perceptions and are more likely to take risks that expose them to HIV. This include having multiple and concurrent partnerships (MCP), inconsistent use of condoms, transactional and intergeneration sex. It is evident that AGYW lack inadequate and user-friendly access to HIV prevention services including HIV testing, PrEP, PEP, condoms, SRH Services. More than often interventions are not age appropriate, gender sensitive or responsive, and tend to deal with symptoms rather than underlying causes. Equally adolescents are reluctant to seek services that require the consent of a parent, guardian or spouse, such as accessing RSH services including family planning (FP).

In addressing these challenges, the Road map will use the combination prevention approach to deliver layered differentiated and targeted packages of interventions that are age and gender appropriate and in particular resonate with individual needs. The strategies and interventions will aim to transform gender roles, and over turn gender norms that create risk and HIV vulnerability among AGYW. The interventions will empower AGYW enabling them to access assets and resources, facilitate functionality of women's networks, and strengthen grassroots women led organizations.

The packages will include among other services SBCC, CSE, PrEP, PEP, Condoms, HTS, ART, Social protection (cash transfers), economic empowerment, PSS, STI management, and SRH. They will also include interventions to keep girls in schools, life skills, and strategies to minimise exposure to sexual and gender-based violence.

Eswatini will explore and strengthen the use of gender transformative (Stepping Stones, SASA, DREAMS), age and culturally appropriate comprehensive sexuality education for both in and out of school AGYW and their male sexual partners.

4.2.3 Adolescent Boys and Men in Setting with High HIV Incidence

Estimates and Projection data (2022) shows HIV prevalence for men 15 years and above at 19.41% compared to women (36.0%). In 2021 the Projections shows that a total of 2180 new infections and were projected to increase to 2317 in 2024. A review of the same data shows that 78165 men were living with HIV and only 66121 had been enrolled on ART. Approximately 12,044 are yet to be enrolled on ART.

A review of the progress made on the 95-95-95 cascade, the data shows that almost 100% of men 15 years and above have tested for HIV and know their HIV status. Equally 100% of those who know their positive HIV status have been enrolled on ART with 98% of those enrolled on ART have achieved viral suppression.

Focusing on women alone will not turn around the trajectory of the HIV epidemic and in particular new infections. It therefore requires a concerted and strategic re-orientation to put men and boys at the centre

[39] HIV Estimates and Projections (2022, UNAIDS

of the response, and make them to be part of the solution. A reduction of new infections among men and boys will have significant benefits for women and girls, and even contribute to the reduction of paediatric infections. It is therefore necessary to bring to scale, intensify and accelerate, combination and precision HIV prevention for boys and men, premised on differentiated service delivery models.

Scaling up HIV prevention for boys and men will require greater focus on increasing service access outside clinic settings, including HIV testing (e.g. community-based and self-testing), strengthening linkage with ART programme, increasing availability and accessibility of condoms and lubricants, making PrEP and PEP available and easily accessible, screening for STIs, providing linkages to treatment, ensuring availability of comprehensive SRH services.

Specific interventions needs to be developed targeting migrant and mobile male workers given the high risks involved. Mobile and migrant workers include truck and public transport drivers, men in uniformed services (The Army, Police, security guards), and migrant workers working in textile factories, plantations and commercial firms.

HIV prevention packages for men should be appropriately packaged based on the needs of specific target groups. The packages should include but not limited to SBCC, HTS (including self-testing), ART, PrEP, PEP, Condoms and lubricants, control and treatment of STIs, interventions to reduce or eliminate stigma and discrimination. Access to comprehensive SRH for men should be part of the package.

Intensifying demand creation for HIV prevention services among boys and men is key to the success of men HIV response. This would also include creating awareness of the individual and collective efficacy of the different interventions.

Men will be sufficiently sensitised on the need to prevent GBV and IPV, negative social and cultural norms and practices that fuel the spread of HIV, and participate in empowerment of their female sexual partners. For this to happen it demands gender-transformative programmes, that will promote gender equality, respect, protect and fulfil the rights of both men and women. It is also important to address issues of harmful masculinities and gender values, including values that influence boys and men to seek health care services such as HIV testing or STI diagnosis and treatment.

4.2.4 Condom Programming

Condoms have consistently remained a strategic triple prevention method for HIV, unplanned pregnancies and other kinds of STIs. They are among the low-cost options for most people at high risk of acquiring HIV. Despite their effectiveness, correct and consistent condom use remains low especially with male clients of sex workers or in stable non-cohabiting relationships. Condom and lubricants promotion and distribution has improved over the years. Table 15, below shows the number of male and female condoms distributed between 2020 and 2022.

Table 15: Condoms distribution

Year	Male		Female		Total	
	Condoms distributed @ year	% of annual target	Total condoms distributed	% of annual target	Total condoms distributed	% of annual target
2020	8,662,550	30	691,811	93	9,354,361	30
2021	4,912,139	16	280,317	36	5,293,456	16
2022	9,900,786	31	383,117	47	10,283,903	31

Source: Estimates and Projections Report , UNAIDS, 2022

Condom stockouts have been reported in different regions in the country. Access has been limited by availability of appropriate and user friendly outlets including insufficient public community-based dispensers.

The Road Map strategies aim to improve availability, accessibility and consistent use of both male and female condoms. When used correctly and consistently condoms have been effective in reducing HIV infection among discordant couples, during anal sex. Condom use by sex workers have shown significant reductions in new infections in different epidemic settings. The use of condom-compatible lubricant has equally reduced condom failure.

Demand creation will be strengthened, including strengthening the supply and distribution systems, and social marketing especially at the community and work place setting. Special outlets will be established in user-friendly locations for key and vulnerable populations especially in places men congregate. To expand community level condom promotion and distribution, Eswatini will strengthen partnerships with community-based organisations (CBOs) to provide education on condoms and demystify myths and misconceptions on its use.

4.2.5 ARV – Based HIV Prevention

Available evidence shows that ARVs have great potential in preventing HIV transmission. While these services are distinct, they are complementary. Therefore promoting, scaling up, intensifying and accelerating provision of ART, PrEP, PEP and PMTCT for HIV prevention will be intensified. Communities will be mobilised and offered HTS as a strategic entry point to access any other HIV prevention services. HTS will be expanded and decentralised to community level. Self-testing will be promoted and supported. Qualified FBOs and other community based organisations will be able to provide differentiated HTS to different key and vulnerable populations. At health facility level task shifting will be strengthened to allow qualified nurses to initiate ART, especially in rural areas.

4.2.5.1 Antiretroviral-Based HIV Prevention (treatment as prevention)

In 2021, available data indicates that Eswatini had 219, 702 people estimated to be living with HIV. 98% had been enrolled on ART. Data analysis further shows that approximately 66,121 men living with HIV are on ART[40]. Provision of ART will be scaled up and coverage increased among PLHIV. ART will be provided to improve quality of life of PLHIV and contribute to HIV prevention. Communities will be

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[40] SHIMS-3, 2021 / and Estimates and Projections 2022

mobilised and offered testing. For people who are HIV positive they will be linked to treatment, offered ART, and supported to adhere and remain on treatment in order to achieve viral suppression. Available evidence shows that undetectable virus is Untransmittable. (U=U). This is the ultimate contribution of ART to HIV prevention.

Eswatini will continuously review available and select the best options for its people including the introduction and use of single pills and injectable ARV. Treatment and control of opportunistic infections such as TB and hepatitis, will be intensified. Community-based organisations will be capacitated to ensure community-based treatment interventions, adherence support and treatment literacy.

4.2.5.2 Pre-Exposure Prophylaxis

When taken consistently, PrEP has proved effective in reducing the risk of HIV by up to 92%. It is less effective if it is not taken consistently and hence the need to improve awareness and knowledge of PrEP In the cases of Eswatini PrEP will be provided as part of a package with other HIV prevention services such as condoms, SMC, and prevention and control of STIs.

PrEP is currently being offered to eligible, HIV-negative individuals who are at substantial risk of acquiring HIV infection as a daily dose. Eight population groups including AGYW (16-24 years), pregnant and lactating women, serodiscordant couples, FSW, MSM, clients with sexually transmitted infections (STIs), males (30-34 years) and transgender people have been prioritised to receive PrEP However, Eswatini moved away from giving PrEP to target populations to avoid stigmatization.

During the Road Map period, PrEP will be rolled out to communities through existing structures such as health clinics, qualified NGOs outreach programmes, through private health practitioners and private pharmacies.

Eswatini will further explore the introduction and registration of new forms of PrEP Introduction of new forms of PrEP will also require fastracking the review and registration process, and revision of the National PrEP guidelines. Delays in registration could potentially compromise HIV prevention efforts especially among AGYW, ABYM and key and vulnerable populations. As of September 2023, CAB-LA injectable PrEP had not been approved or submitted for registration in Eswatini despite its efficacy and availability. Eswatini is currently conducting a pilot study on the introduction of the Dapivirine Vaginal ring in six facilities. It is anticipated that the results of the pilot study will be used to Fasttrack the introduction and rollout of the ring especially targeting AGYW, discordant couples and female sex workers.

Monitoring of PrEP will be conducted as part of the national M&E system with data channelled through the DHIS2, and through community led monitoring – based on agreed indicators. A key monitoring component is tracking PrEP usage and adherence. If not well monitored drug resistant could be a problem in the future. A key starting point to increase demand and use of PrEP will be to intensify social and community mobilisation in addition to social and behaviour change communication.

4.2.5.3 Post Exposure Prophylaxis

Traditionally PEP has been offered as a part of occupational health practice to prevent HIV infection. PEP has since been expanded to include HIV prevention among people who have been exposed through GBV, rape or other forms of physical violence. PEP for HIV consists of a comprehensive set of services including - first aid care, counselling and risk assessment, HIV testing and depending on the risk assessment, the short term (28-day) provision of ARV with follow up support. However, health care

service providers often report that not all individuals receiving PEP come back for follow up HIV testing after three months.

The Road Map advocates for increased awareness and demand creation, deliberate decentralisation of PEP services to community-based facilities, and engagement with CSO to provide follow up support and. care services.

4.2.5.4 Prevention of Mother To Child Transmission (PMTCT) of HIV

PMTCT objective is to eliminate mother to children transmission. Hence emphasis will be on prevention of primary infections and making sure that pregnant women are identified and offered HIV testing immediately. Those that are HIV positive will be linked to treatment and offered ART for their own health and for PMTCT. Those that are not HIV positive will be linked to other HIV prevention interventions including PrEP, condoms and SMC for their male partners. All women attending ANC will be offered services to control, manage and treat STIs.

Efforts will be made to ensure women on ART are retained and progress to achieve viral suppression. With viral suppression the likelihood of transmitting the HIV virus to their children is unlikely. Most children get infected during labour and delivery and hence the importance of improving the quality of services. New infections also occur during breastfeeding period. This will require increased focused on primary prevention for women and their sexual partners.

Services will be aligned with the four prongs of PMTCT. Specific interventions will focus on ensuring primary prevention, address the unmet needs for family planning and improving the quality of life of HIV positive pregnant women and their sexual partners. Linkages will be strengthened with other HIV prevention services such as condom promotion, provision of PrEP, referrals, and counselling in the case of discordant couples. This will ensure a comprehensive package of services. Services will also be provided to HIV pregnant women who wish to prevent unwanted pregnancies. Provision of services will be aligned with the PMTCT cascade.

4.3 COVID 19 Response

The COVID 19 pandemic exacerbated existing inequalities, created setback and pushed the HIV and AIDS response off track. Available services reeled under acute pressures, exposing the fragilities and resilience of health and community systems. The pandemic disrupted and brought to a halt community outreach services and the supply chain for medicines and other health commodities. The pandemic affected KVP and marginalized communities disproportionately especially those with underlying conditions such as AIDS, high blood pressure, diabetes, cancer, obesity, pregnant women and the elderly.

In the wake of fear and uncertainty that emerged following COVID 19, pandemic - stigma, discrimination, mental health issues and GBV among others quickly followed. COVID 19 and stigma exacerbated existing inequalities such as income, employment, and freedom to congregate.

Although COVID19 is no longer a major public health threat, its potential re-occurrence and or occurrence of another pandemic could disrupt HIV prevention services. The pandemic threat demand that Eswatini be prepared to respond to such pandemics quickly. In doing so they must develop strategies that will sustain service delivery in emergency and post emergency situations, address access bottlenecks

including stigma, exclusion and un-equitable distribution of services including diagnosis, testing and ensuring availability of vaccines.

Civil society organizations (CSO) can facilitate community-based support to people affected by pandemics in addressing immediate challenges. Preparedness will include promoting comprehensive pandemic prevention and treatment strategies. Efforts will be made to ensure community-based services are available, sustained, acceptable and accessible to all people in need. As pandemics are likely to have different characteristics and drivers, it will require differentiated and contextualized programmes and targeted interventions to mitigate their impact on HIV prevention efforts.

4.4 Cross Cutting Strategies

The following cross cutting strategies will apply across all core HIV prevention interventions presented this road map. While the strategies are distinct, they are complementary and intersect to re-enforce each other. Their application will follow the same principle of combination approach (integration).

4.4.1 Combination Prevention

It is evident that no one HIV prevention strategy alone will stop the epidemic and hence the need to adopt and implement the combination prevention approach using packages with high impact interventions. In addition to focusing on combination prevention, it is also strategic that service providers consistently apply "precision prevention" where specific interventions and medical products target specific and well defined problems and provide precision solutions. The approach is characterised by interventions that are health rights and evidence-based, people-centred, coupled with a mix of strategies that address biomedical, structural and behavioural interventions. Combination prevention focus on results, promotes accountability and strategic partnerships. The approach allows implementing partners to package interventions appropriately moving away from vertical programme implementation. The approach will facilitate the integration of biomedical, structural and behavioural interventions thereby increasing synergy and improve efficiency and efficacy. The approach will reduce beneficiary fatigue and improve adherence and retention.

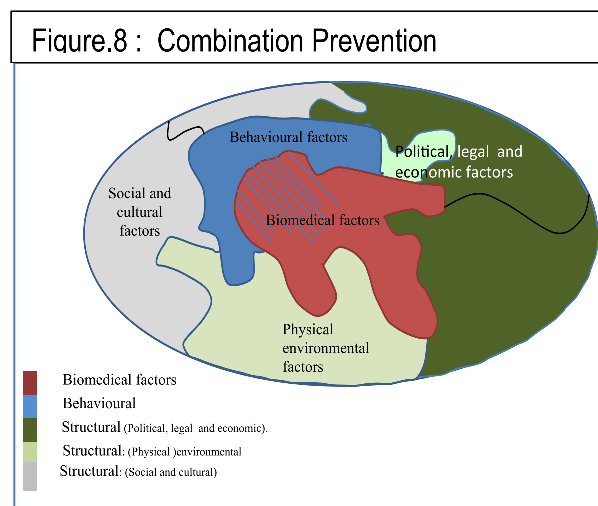

Figure.8 : Combination Prevention

Some of the interventions that constitute the combination prevention package include SBCC, condoms, Prep, PEP, SMC and ART. ART will reduce HIV transmission, while PrEP and SMC will reduce susceptibility. Condoms are critical to prevent HIV transmission, STI infections and unwanted pregnancies. Reinvigorated SBCC and community mobilisation programmes will focus more on social patterns and norms that influence key sexual risks such as having multiple sexual partners and age disparate sex. Cash transfers, economic incentives and empowerment strategies will primarily target structural drivers of the epidemic such as GBV, social and economic inequalities, poverty and income

disparities that trigger transactional, inter-generational sex and MCPs. Structural interventions will also include keeping girls in school, addressing societal enablers and building social assets.

4.4.2 Advocacy and Communication

Effective advocacy and communication will aim at influencing changes in service delivery, bridging the gaps between availability, access and utilisation. At national level advocacy will focus on influencing and shaping HIV prevention policies and legislation, strengthening an enabling social, policy and legal enabling environment. At regional level the core focus will be to ensure services are available, accessible and are being utilised. It will also focus on influencing service delivery practices, and advocating for compliance with policies, legislations and best practices that impact on HIV protection. At community level advocacy will focus on galvanising communities and community leaders to initiate local responses to change risk environment and promote HIV prevention. The approach will support and promote community-based, and community-led HIV prevention interventions.

4.4.3 Social and Behaviour Change Communication (SBCC)

SBCC will be used primarily to create awareness, improve comprehensive knowledge of HIV and AIDS in addition to HIV prevention services available. Despite the efforts made in the past, awareness and comprehensive knowledge of services such as PrEP/PEP, the relationship between STIs and HIV infection, the full benefits of SMC, the dual role of Condoms, the role of HTS as a critical entry point and even SRHR services remain inadequate to influence mass acceptance. The combination of improved comprehensive knowledge, improved risk perception and people knowing their HIV status will enable people to make informed decisions and choices on HIV prevention. SBCC will be a primary strategy for demand creation and retention across all services

Evidence shows effective SBCC have been able to influence changes in social norms, believes, values and attitude, practices and behaviours in favour of HIV prevention, improved individual risk perceptions leading to reductions in incidence of multiple and concurrent sexual partnerships (MCPs), alcohol and drug abuse, and in some instances, gender-based violence (GBV).

A key anticipated role of SBCC will be to leverage new and emerging HIV prevention technologies, and strategic partnerships and alliance necessary for promoting and strengthening HIV prevention accountability and leadership, and institutionalising HIV Prevention Community of Practice.

SBCC implementation will be targeted, intensified and coverage expanded. Specific SBCC interventions are ineffective when implemented alone. They will need to be integrated with the core targeted packages for the different population groups. SBCC will also depend on effective implementation of other strategies such as social and community mobilisation, advocacy and communication. This combination is necessary to address other challenges such as gender inequality, gender-based violence, and other social and economic inequalities preventing HIV prevention.

SBCC will highlight challenges posed by other epidemics such as COVID 19 and potential ways for mitigating the impacts to avoid potential fallout of HIV prevention

During the implementation of the Road Map the approaches providing basic knowledge, awareness, and general behaviour change messages will need to be replaced with approaches informed by local

evidence on factors shaping behaviours and programme models, which have been effective in achieving better outcomes.

4.4.4 Social and community mobilisation

Social and community mobilisation will serve as an entry point in engaging communities and for establishing or strengthening strategic partnerships that will address negative social and cultural norms and practices that negatively impact on HIV prevention. The strategy will also facilitate communities identifying other community-based HIV prevention challenges and the subsequent community-based and community-led solutions. The strategy will also complement demand creation. Community and social mobilization will be used as a tool for community outreach and engagement. Community mobilization will be used as a platform to empower communities especially KVP, building coalitions and as a platform for them to voice their views and be heard. The process of social mobilisation will contribute to strengthening community systems as a platform for networking, information sharing, transfer of best practices and in improving community-led monitoring (CLM)

Implementing partners will use social and community mobilisation processes to build trust, improve leadership and accountability. Service providers will be transparent to ensure that decisions that affect the community are made in a socially and participatory way. Participatory approaches such as community conversations, dialogues and interpersonal communications are among the strategies that will be used. However the effectiveness and efficiency of community mobilisation will depend on how well communities are sensitised and organised, mobilisation of community resources and skills, and to a large extent on community volunteerism.

4.4.5 Addressing Human Rights, Policy, and Legal Barriers to HIV Prevention.

Addressing human rights, social, policy and legal barriers to HIV prevention will be a primary focus during the implementation of the Road Map. Underlying factors contributing to these challenges include insufficient political commitment and investment, inadequate attention to data systems and management, and insufficient action to address the social and contextual complexities experienced by vulnerable and marginalized groups, inadequate compliance and implementation of existing guidelines, policies or legislation. The conflict between religious faith and evidence-based best practices has been a critical bottleneck to access to services especially for key population.

Overall lack of an enabling human rights, social, policy and legal environment makes services availability, access and utilisation by KVP a daunting operational challenge. Some punitive laws that criminalize key populations remain in place and tend to prevent access to HIV prevention services. These challenges are compounded by inadequate and ineffective coordination, leadership and accountability for HIV prevention.

It is anticipated that during the implementation of the Road Map, policies and laws will be reviewed, reformed and aligned with the current best practices. Advocacy will be intensified to promote appropriate policies or legislation that support and advance HIV prevention. Such instruments will address negative social-cultural practices, stigma and discrimination, GBV, gender inequalities, protection, respect and fulfilment of human rights. Implementing partners will be capacitated to address human-rights challenges that prevent HIV prevention programming and service delivery.

Efforts will be made to review and update current technical HIV prevention guidelines and protocols, and where such documents are missing new ones will be developed.

Section 5: Coordination, Leadership and Accountability

Note: Details of the coordination and accountability strategies are contained in the separate document entitled - "Coordination and Accountability Framework". This section is intended to provide an overview and not a detailed descriptive of the content of the Framework. Readers are encouraged to read the detailed Framework.

5.1 Strengthening HIV Prevention Coordination

There are many and diverse stakeholders at national, regional and community level involved with HIV prevention with different mandates and programmatic focus. They also have different organisational mandates, leadership and governance structures, operational systems, different methods of accountability, planning, timeframes, different formats and channels of reporting that make coordination and management of the HIV response complex, dynamic and demanding. HIV prevention is complex and dynamic demanding innovative multifaceted mechanisms that support multisectoralism and decentralised approach that transcend beyond individual organisations and sectors.

Despite the complexity of the response coordination and management, stakeholders are increasingly demanding for clarity of roles and responsibilities, transparency, ownership and good governance. There is increasing demand for a better and improved enabling policy, social and legal environment that support strategic partnerships and alliances. The call demands for strengthening existing coordinating structures at national, regional and, sector and community level.

NERCHA is mandated under law, to coordinate the national multisectoral HIV response. NERCHA has established multisectoral thematic sub committees such as the National HIV Prevention Technical Working Group to support thematic coordination and leadership. At regional level, HIV response is coordinated through Regional Multi-Sectoral HIV and AIDS Coordinating Committee (REMSHACC), Tinkhundla Multi-sectoral HIV and AIDS Coordinating Committee (TMSHACC) and the Chiefdom Multi-sectoral HIV and AIDS Coordinating Committee (CHIMSHACC). At sector level specific semi-autonomous sectoral coordinating structures have been established. Their mandates, roles, responsibilities and accountability are articulated in the National Coordination and Accountability Framework. Coordination with development partner is facilitated by NERCHA through different platforms including the partnership forum and in collaboration with UNAIDS, through the Joint UN Team on HIV and AIDS. Ministry of Health coordinates the health sector HIV prevention programmes, given its national mandate and comparative advantage.

Eswatini has developed the National HIV Prevention and Accountability Framework that focus on improving and strengthening coordination and accountability efficiency and effectiveness. The Framework also promotes meaningful engagement and participation by all stakeholders, especially key and vulnerable populations. The Framework is premised on the three "three-One" principles of coordination of national multisectoral HIV response. The Framework has clarified stakeholders mandates, roles and responsibilities, and identifies specific areas of accountability.

The implementation of the Framework will narrow the gap between supply and demand for HIV prevention services by facilitating equitable distribution of service, harmonising service between service providers, and rationalise the use of financial, human resources and technological resources – including strategic information and evidence-based data.

5.2 Strengthening HIV Prevention Accountability

Stakeholders' accountability for HIV prevention is a strategic priority for the HIV Prevention 2025 Road Map. All service providers at all levels of the response will be held accountable for their work, the resources they use and for promises their make to beneficiary populations.

5.3 Expanding and Strengthening the Multisectoral HIV Prevention Response

The multisectoral approach has expanded the multisectoral HIV prevention response through outreach, population and geographical coverage bringing services closer to the people.

The success of sector-based HIV prevention programmes largely depend on how well the sector's target population is mobilised, sensitised and engaged. In addition to having an enabling social, policy and legal environment that enhances services availability, access and utilisation. It is critical that sectors address and remove human rights, policy and legal barriers to access services. Stigma, discrimination and violations of human rights stand out as key barriers. In most cases sectors have focused on addressing the needs of staff at the workplace. It is equally important that sectors also plan and deliver HIV prevention services in areas they have capital development projects – involving the communities that live in the projects catchment area.

The Road Map will advocate for sectors to review their current programmes in order to mainstream high impact HIV prevention interventions. The process should also include strengthening the enabling policy environment.

Section 6: Monitoring the Road Map Implementation Progress and Performance

Strategic information and evidence-based data have become strong agents for change. They are the most valuable asset in influencing decisions, choices, actions, behaviours and resource allocations. In scaling up HIV prevention, the need for empirical data and strategic information becomes more crucial. Hence the need to develop a robust HIV prevention monitoring and evaluation plan. While the M&E data

will be key in influencing decision making, policy formulation, accountability and resource allocation, it will also enhance HIV and AIDS knowledge management.

The current HIV and AIDS M&E plan will be reviewed to align them with the new NSF and the HIV prevention road Map 2025. Human resource capacity will be strengthened to support efficient and effective monitoring of the Road Map.

4.5 Community Led Monitoring (CLM)

Communities will be capacitated to implement "community led monitoring (CLM)" for purposes of communities tracking the progress and performance of the HIV prevention Road Map. Data will be collected and reported on a monthly basis by participating implementing partners. Data collection and reporting tools will be reviewed and harmonised with the national M&E tools. Reporting will be through the District Health Information System (DHIS 2) platform.

Routine monitoring will aim to ascertain the extent to which planned activities are being implemented and contribute to the achievement of the agreed targets. The process will also identify emerging bottlenecks likely to negatively affect the Road Map implementation. Implementing partners will track provision of services to ensure adequate services and client coverage. At the national level NERCHA will track how financial, human resources and technological resources are being used to support HIV prevention implementation.

The quality of data and strategic information will be strengthened throughout the continuum of the M&E system, i.e., from having well defined indicators, quality data collection tools, improved data analysis and management process, reporting systems and tools, data verification and validation processes, and how data is eventually managed for dissemination and use. Training and retaining of relevant personnel involved will be conducted.

4.6 Programme Evaluation - Tracking Progress and Results.

A joint mid -term review (MTR) will be conducted in early 2024, to determine the progress made towards the midterm targets. The end-term evaluation will be conducted in 2025, to assess efficient use of resources, the extent to which the capacity has been developed and the impact of strategic partnerships. The end term will also ascertain the impact of the strategic plan, and whether the strategic objectives and end term result have been achieved. Both the MTR and end term review (ETR) will be supported by an independent consultant to ensure objectivity of the findings.

4.7 Research, Survey and Special Studies

Eswatini will plan and conduct specific studies based on emerging needs. Such studies could include a study looking at the extent that human rights, policy and legal barriers have been addressed, and SHIMS. The studies will be premised on the need to generate new data, information and knowledge, and in particular generate data for missing baselines.

Section 7: Annexes

Annex 1: Glossary of terms used in the Road Map

Coordination	The process of bringing together and supporting stakeholders to efficiently and effectively coordinate and plan their activities in a manner that enhances synergy, reduces duplication, increases skills and knowledge transfer
Effectiveness	The extent to which an intervention objective was achieved or is expected to be achieved
Efficiency	A measure of how economically resources / inputs are converted to results
Empowerment	Action taken to overcome obstacles arising from inequality between people and between gender – male and female.
Evidence Based	A process that allows planners to use available evidence to inform their choices and decisions on interventions and strategies to achieve specific desired results.
Gender	Refers to the social conceptualization of males and female based on social differences and relations between them that are learnt, changeable over time, and have wide variations across cultures. They are context specific and can be modified.
Gender equality	Entails the concept that all human beings, both men and women are free to develop their personal abilities or make choices without limitations set by stereotypes, rigid gender roles and prejudices; so that their rights, responsibilities, and opportunities do not depend on whether they are born male or female.
Gender-based violence	Gender-based violence is a form of violence derived from the unequal power relationship between men and women. It is the type of violence where either a man or a woman exerts his or her power over the other with the intention to harm, intimidate, and control the other person
Human rights	The universally agreed upon rights with regard to the right to life, social and economic welfare, which should be enjoyed by all human beings irrespective of their sex, colour, or creed.
Impact result	Long-term positive changes in the lives of people, condition or organisation arising from an intervention.
Input	Pre-requisite resources (human, information, finance) required to support activity implementation to produce outputs.
Outcome	A change in behaviour (values, attitudes, practices etc.) of, or the use of new capacities (laws, policies etc.) by target group (people and institutions).
Output	Operational changes or new capacities (knowledge, skills and equipment, products and services), which result from the completion of activities within a specified intervention in a given time.
Region	An administrative geographical area with clearly defined boundaries. Eswatini has 4 administrative regions.
Result	A measurable or describable change in the lives of people or organisations resulting from a cause-and-effect relationship or programme intervention.

Results based planning	Part of the results-based management approach: it involves using evidence to understand the current situation and weaknesses, and then to plan based on the current situation and other evidence of what is most cost effective to address the weaknesses in the program.
Risks	The probability that a person may be affected negatively by a condition or behaviour i.e. acquiring HIV infection
Sector	A section of society that has common characteristics or interests. The mandates of sectors differ depending on the nature of their core business. The categorisation of the sectors is provided in Annex 4
Sex	A biological construct defining the physical differences that males and females are born with
Three Ones principle	Three Ones principle means a country having one national coordinating authority, one national strategic framework and one national M&E framework.
Vulnerability	Results from a range of external factors[41] that are often beyond the ability of a person to control that increases the possibilities of their exposure to HIV infection

Annex 2: People consulted or participated in FGD and other consultative workshops.

Note: because size this annex is provided as a stand-alone document. – to be updated after the. validation workshop / finalisation of the strategy.

[41] This may include personal factors such as lack of knowledge and skills required to protect oneself, and others; factors pertaining to the quality and coverage of services such as inaccessibility of services due to distance, cost etc., and societal factors such as social and cultural norms, practices beliefs and laws that stigmatize and disempower certain populations such as women and girls.